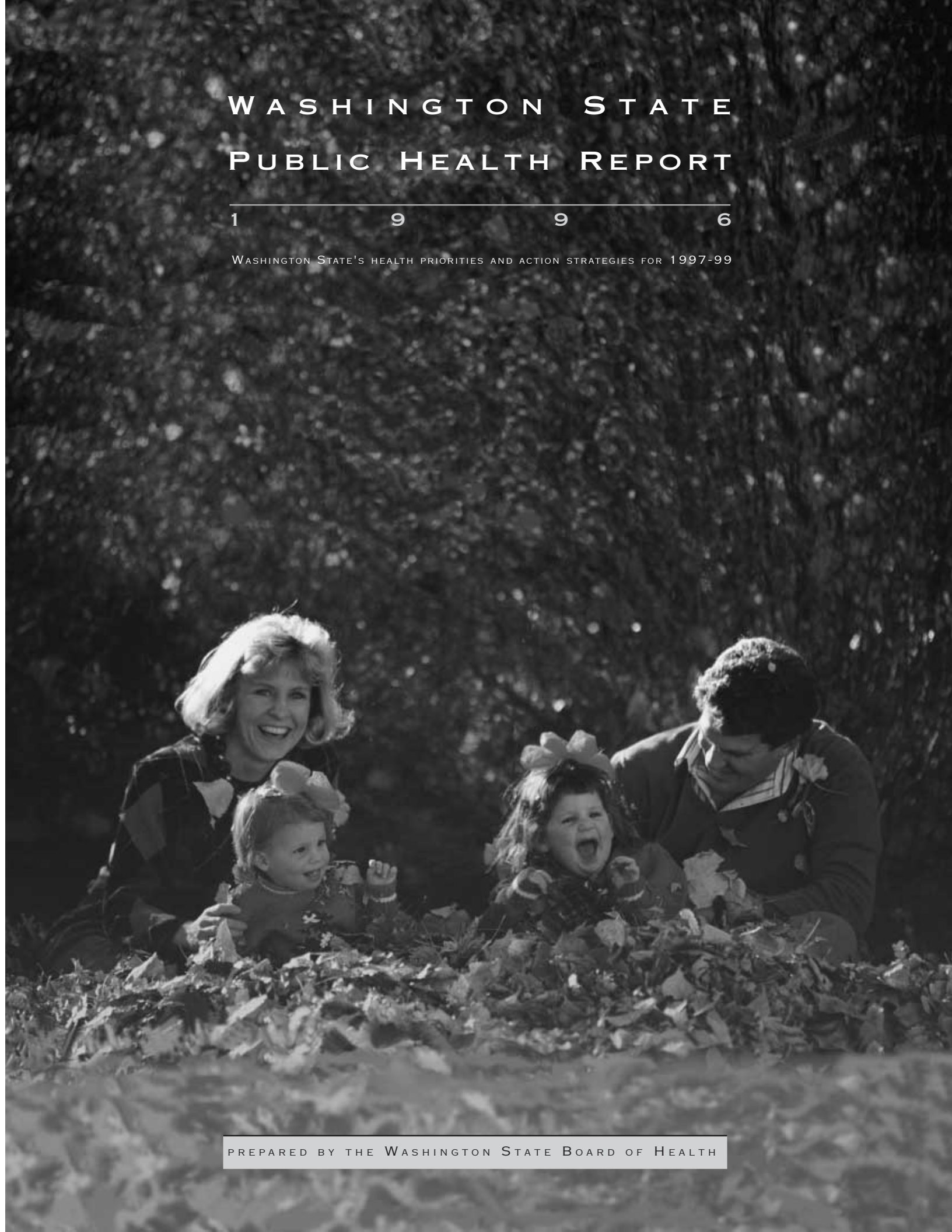

Washington State Public Health Report

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Washington State's health priorities and action strategies for 1997-99

prepared by the Washington State Board of Health

Contents

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STATE OF WASHINGTON
WASHINGTON STATE BOARD OF HEALTH
1102 SE Quince Street • PO Box 47990
Olympia, Washington 98504-7990

January 10, 1996

The Honorable Mike Lowry
Governor of Washington
Legislative Building
Olympia, WA 98504

Dear Governor Lowry:

It is with pleasure that I forward to you the *1996 Washington State Public Health Report* which fulfills the statutory mandate of the State Board of Health set forth in RCW 43.20.050(1)(b).

We have outlined what we believe the Washington State Priority Health Goals should be for the next biennium. With your approval, the recommended Action Strategies for state agencies will ensure that community education, health intervention, regulatory approaches, and funding resources are best blended to promote the health of our citizens. This *Report* is not merely a consensus of this Board, but the distillation of the best advice we received from local health departments/districts, state health care agencies, professional and community organizations, and numerous citizens. With appreciation to all of them for their counsel, we submit this *Report*.

As a Board and as individual members, we are most respectful of the heritage of service to the needs of public health in Washington that we are charged with continuing. We are especially concerned about the unmet health needs of many Washington residents; of diverse communities with special needs in both rural, as well as many urban areas. We are concerned about the ever-changing dynamics within the health care system today that appears to have forgotten or neglected them. We pledge to keep our forum open to all, to listen to their concerns, and always take appropriate action on behalf of the citizens of our state.

With our thanks to you for the leadership you have shown in health affairs, I remain

Sincerely,

Warren Featherstone Reid
Chair

We Envision A Future In Which:

Children are born healthy in a society that respects and nurtures individuals throughout life, providing each with the opportunity to develop and express her or his potential in ways that are personally satisfying and socially constructive.

The environment we share is clean, with physical, chemical and biological hazards reduced to levels compatible with both community health and a sound economy.

Individuals care for themselves and others and have the opportunity to learn and apply health-promoting practices in family, school and other community environments.

Infectious diseases are controlled, and other preventable illnesses and injuries are minimized.

All citizens who need special support or care in order to continue to be part of a fulfilling community life receive what they need.

Informed and interested citizens participate actively in formulating health policy and deciding how public and private resources will be allocated for health maintenance and improvement.

Public agencies cooperate and collaborate with each other and with private sector organizations in addressing problems that put people at risk of illness or injury and impact community health status.

Individuals and institutions have an abiding commitment to the responsible use of health and medical care services.

A flexible and creative health and illness care system respects cultural and geographic diversity, focuses on outcomes and responds proactively to emerging health problems as it emphasizes prevention, education, and early intervention, and makes quality affordable care readily available and accessible to all.

With this vision of our future, we look forward to living in a society in which the quality of the public's health is transformed from a liability demanding attention and engagement to an asset enabling us to meet the challenges of the twenty-first century.

Washington State Public Health Report

How to use this report

Preparation of the *1996 Washington State Public Health Report* is mandated under RCW 43.20. The *Report's* purpose is to outline the State's health priorities for the 1997-99 biennium and suggest Action Strategies for use by state agency administrators in preparing budgets and executive request legislation. It is presented to the Governor in January of each even-numbered year. This is the fourth *State Public Health Report.*

Responsibility for preparing the *Report* is vested in the Washington State Board of Health. The State Board was established under Article XX of the State Constitution in 1889. Creation of the *State Public Health Report* is one way the State Board fulfills its mandate to provide a forum for the development of health policy in Washington. The *Report* is a vehicle for initiating and validating citizen and professional involvement in health policy formulation, and for utilizing this involvement to explore ways to improve the health of Washington's people.

The *State Public Health Report* is expressive of public health's mission in assuring conditions in which people can be healthy. Through making sound use of data, analyzing information pertaining to various illness conditions, and evaluating strategic approaches to prevention, promotion, and intervention, the *Report* serves as a blueprint for assuring healthy communities and a healthy State. Evaluation reveals state agencies make use of the *State Public Health Report* as part of their ongoing planning and budgetary processes.

The *1996 State Public Health Report* presents the State Board of Health's Vision of a Healthy Washington and seven Priority Health Goals recommended for primary attention during the 1997-99 biennium. These goals reflect the expressed needs and interests of Washington's citizens and are compatible with the three overarching national goals delineated in the U.S. Department of Health and Human Services (DHHS), Public Health Service's *Healthy People 2000: National Health Promotion and Disease Prevention Objectives:*

- Increase the span of healthy life for Americans
- Reduce health disparities among Americans
- Achieve access to preventive services for all Americans.

Like its national counterpart, the *1996 Washington State Public Health Report* places emphasis on reducing preventable morbidity and disability, lessening health disparities between population groups, and improving the quality, not just the length of life. The selection of the seven Goals delineated in this *Report* does not imply that there are not other health problems of concern to Washington residents and health professionals.

With explicit acknowledgment of limited available resources and recognizing the importance of seeing these resources used wisely and well, the State Board used five criteria in selecting its Priority Health Goals:

- Will progress toward the Goal significantly improve the health of all the people of Washington?
- Does the Goal deal with a condition of concern to most Washington citizens?
- Are private and public resources adequate to make significant progress toward the Goal?
- Is there consensus among experts and citizens about what needs to be done to accomplish the Goal?
- Can significant progress toward the Goal be achieved in two years?

After evaluation of the *1994 State Public Health Report,* examination of newly-available data, and consultation with state and local agencies, and members of the legislative and executive branches of state government, the State Board of Health reaffirmed its 1994 selection of seven Priority Health Goals for incorporation in the *1996 Report.*

Each set of Action Strategies pertaining to the State Priority Health Goals begins with a statement on "Accountability, Health Efficacy, and Cost Effectiveness: The Public Health Context". From the hundreds of suggestions contributed by more than 5,000 citizens, elected officials, agencies, and health professionals across Washington, the *Report* identifies Action Strategies which, when translated into specific legislative and programmatic initiatives, will have a significant positive impact on the health of the people of Washington. The Action Strategies are expressive of public health approaches to addressing challenges through its core functions: health assessment; policy development; assurance; prevention; access and quality; and administration. Each Action Strategy is numbered and ascribed to a specific state agency for implementation. The State Board of Health recognizes many Action Strategies will require significant interagency coordination and collaboration in working to achieve each State Priority Health Goal. The Board expects to monitor progress made in implementing each Strategy and its effectiveness in moving toward the Goals.

The *1996 Washington State Public Health Report* includes legislative and state agency responses to the Goals generated in the past two years. Invaluable input was received from the eight state agencies mandated by the Legislature to provide assistance in the *Report*'s preparation: the Departments of Agriculture, Ecology, Health, Labor & Industries, and Social and Health Services; Office of the Superintendent of Public Instruction; Health Care Authority; and Office of the Insurance Commissioner. Relevant information was also received from state agencies not listed in the original legislation, especially the Washington State Patrol, Department of Community, Trade & Economic Development, Washington Traffic Safety Commission, and Washington State Parks and Recreation Commission. The State Board acknowledges and appreciates the efforts of agency directors and secretaries and their staff in sharing their data, values, and department objectives that impact the health of Washington's people.

In collecting input for the *Report,* citizens, local health departments/districts, and state agencies provided "Success Stories". As the ultimate responsibility for a healthy society lies with the citizens themselves, individuals and families portrayed in these Success Stories exemplify initiatives undertaken to improve the health of our communities. These are citizens of which the people of Washington can be proud. An evaluation and order form is available in the back of the *Report.*

Taken as a whole, the *1996 Washington State Public Health Report* provides clear guidance to the executive and legislative branches of state government. It serves as a tool for evaluating different health care strategies and initiatives, a benchmark by which to evaluate progress, and guide for helping to make difficult policy decisions concerning use of limited resources. The *Report* also provides a mirror for Washington citizens to use as they examine their own health and that of their communities. In doing so, they will be able to relate their concerns to a government seeking to serve their interests constructively, as the *1996 Washington State Public Health Report* amply demonstrates.

Both the State Board and Department of Health are responsible for preparing biennial reports to guide improvement of public health status. The *State Public Health Report* lays out priorities and strategies for state agencies, while the Public Health Improvement Plan serves as a blueprint for the public health system, state, tribal, and

local health jurisdictions, local boards of health, and community-based organizations. In the future, a newly-developed State Health Assessment will provide data to identify the health status of Washington residents. Future *State Public Health Reports* and Public Health Improvement Plans will build upon the Assessment's findings and provide a comprehensive vision for the health of Washington State.

Building on activities to gather citizen input for the *1994 Washington State Public Health Report*, substantial efforts were made to assure the views of Washington's people are heard through the *1996 State Public Health Report.* The Washington State Board of Health believes that citizens play a definitive and prized role in helping specify the desired scope of health protection and promotion and the State's role in assuring them. Citizens also help clarify opportunities for action and indicate directions for dealing with complex problems.

The *State Public Health Report* is a comprehensive expression of the State Board's role as a forum for the development of state health policy. It reflects the needs, concerns, and opinions of communities across the State. Only through a committed and ongoing cooperative partnership with the citizenry can the State Board of Health fulfill its vision of serving as a catalyst to identify emerging health problems and solutions and developing effective strategies to ameliorate them.

In preparing the *1996 Report,* the State Board made a strong, systematic, collaborative effort to solicit input from a wide array of individuals, citizen organizations, providers and provider organizations, and local, state, and federal agencies. In selecting methods for gathering information to be used in the *Report,* the State Board adopted the following objectives, with a special emphasis on refining recommended Action Strategies:

- To provide opportunities for the general public, civic groups, and other interested parties to express their opinions about the health needs of Washington, as well as their recommendations about what should be done in response to these needs;
- To provide similar opportunities to professional associations and societies, provider organizations, state agencies, health departments/districts, and other groups that will have a vital role in providing leadership, technical expertise, and human resources to successfully pursue the Goals and implement Action Strategies proposed in the *Report;*
- To invoke from all parties listed above the support and commitment essential to a focused, well-integrated, and adequately-funded effort to accomplish the Goals and Action Strategies identified in the *Report.*

An active and informed population forms the basis and provides momentum for long-term improvement of people's health status. Broad participation by citizens is the best way to ensure a government which is both vigorous and responsive to their needs.

As no single information-gathering technique could satisfy all the above criteria, the State Board utilized a variety of methods to solicit input. Following are descriptions of each.

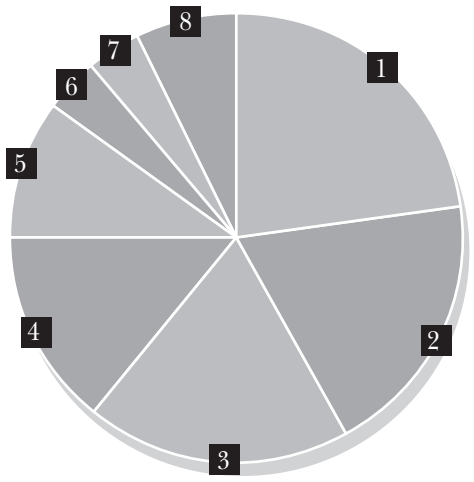
WSU Telephone Survey

A statewide random telephone survey was conducted on behalf of the State Board of Health by the Social and Economic Sciences Research Center at Washington State University. The survey objective was to obtain a broad and representative cross-section of opinions and comments from state residents about their health concerns and priorities. There were 1,568 individuals who took part. There was a geographic spread equivalent to that of the population as a whole, with equal population samples from eastern and western urban and rural areas. The 50-question survey was conducted between August 27 and September 27, 1995. Statistical error was computed as within plus or minus 3%. No substantive differences were found in the opinions of respondents from the various regions of the State, nor in the opinions of respondents from rural and urban areas.

Asked what one health issue posed the most serious threat to their own health and that of their household, respondents most frequently named environmental hazards, including air pollution, agricultural pesticides, and polluted water (22%), followed by lack of exercise and poor eating habits (20%). Asked what health issues should receive the most attention from state government, 23% of respondents said the misuse of alcohol and other drugs, followed by environmental hazards (19%) and access to health services (19%).

Question: What is the most important health area on which state government should work?

1	Misuse of Alcohol & Other Drugs	23%
2	Environmental Hazards	19%
3	Access to Health Services	19%
4	Sexually Transmitted Diseases	14%
5	Injuries & Violence	10%
6	Tobacco Use	4%
7	Mental Health	4%
8	Other	7%



Asked what state government should do to accomplish the State Priority Health Goals, respondents most frequently cited education and preventive health measures (16%), followed by enforcing or establishing stricter laws regarding tobacco, alcohol, and drug use (14%), and cleaning up the environment (12%).

Given information about how state budget dollars are currently allocated, 43% of respondents said more should be spent on health-related programs and less on other programs; 47% said allocations for health-related programs are about right; and 10% said less should be spent on health-related programs.

School Boards

Survey forms were sent to the 1,480 members of Washington's 296 local school boards and educational service districts. Members were asked to rank the State Priority Health Goals according to the priority they would give each for state government action. Reduce the Misuse of Alcohol and Other Drugs ranked first, followed by Reduce Violence and Preventable Injuries, and Assure Access to Health Services. Many comments were received regarding the importance of state government's role in preventing teenage pregnancy, providing prenatal care, and education/intervention services for young and at-risk parents, and health education.

Library Patron Survey

Copies of the *1994 Washington State Public Health Report* were displayed and surveys distributed to patrons in community libraries in all 39 counties. Responses were mailed to the Board offices or sent via electronic mail. Patrons were asked to provide priority rankings for state government involvement in addressing the State Priority Health Goals. Assure Access to Health Services received the highest priority ranking.

Community Public Health and Safety Networks

In cooperation with the Family Policy Council, copies of the *1994 Report* were sent, together with a questionnaire, to all 1,219 members of the 53 local Community Public Health and Safety Networks established under the 1994 Youth Violence Reduction Act. Each Network was asked to submit the three priority outcome areas chosen for Network focus from the eight designated by the Legislature. Of responses received, 100% of networks selected child abuse and neglect (found under the State Priority Health Goal "Reduce the Incidence of Violence and Preventable Injuries") as a priority area for attention.

Community Health Assessments

As part of ongoing planning activity and as required by the Public Health Improvement Plan, Washington's 33 local health departments/districts are conducting community health assessments. Fourteen such assessments were completed as of November 1995. More than 3,000 citizens participated in completed assessment activities. Among the completed assessments, access to health care was perceived to be an ongoing problem, especially in rural areas and among seniors. Teenage pregnancy and alcohol and drug misuse were also perceived as problems requiring attention. Additionally, students at the University of Washington's School of Public Health and Community Medicine provided valuable input.

The Board gratefully acknowledges the contributions of more than 5,000 Washington citizens, elected officials, agencies, and health professionals in the development of the *1996 Washington State Public Health Report.*

Washington State Priority Health Goals

1997 – 1999

Reduce preventable infant morbidity and infant mortality.

Reduce the incidence and preventable consequences of infectious diseases.

Control or reduce exposure to hazards in the environment in which we live, work, and play.

Reduce tobacco use and exposure to secondhand smoke.

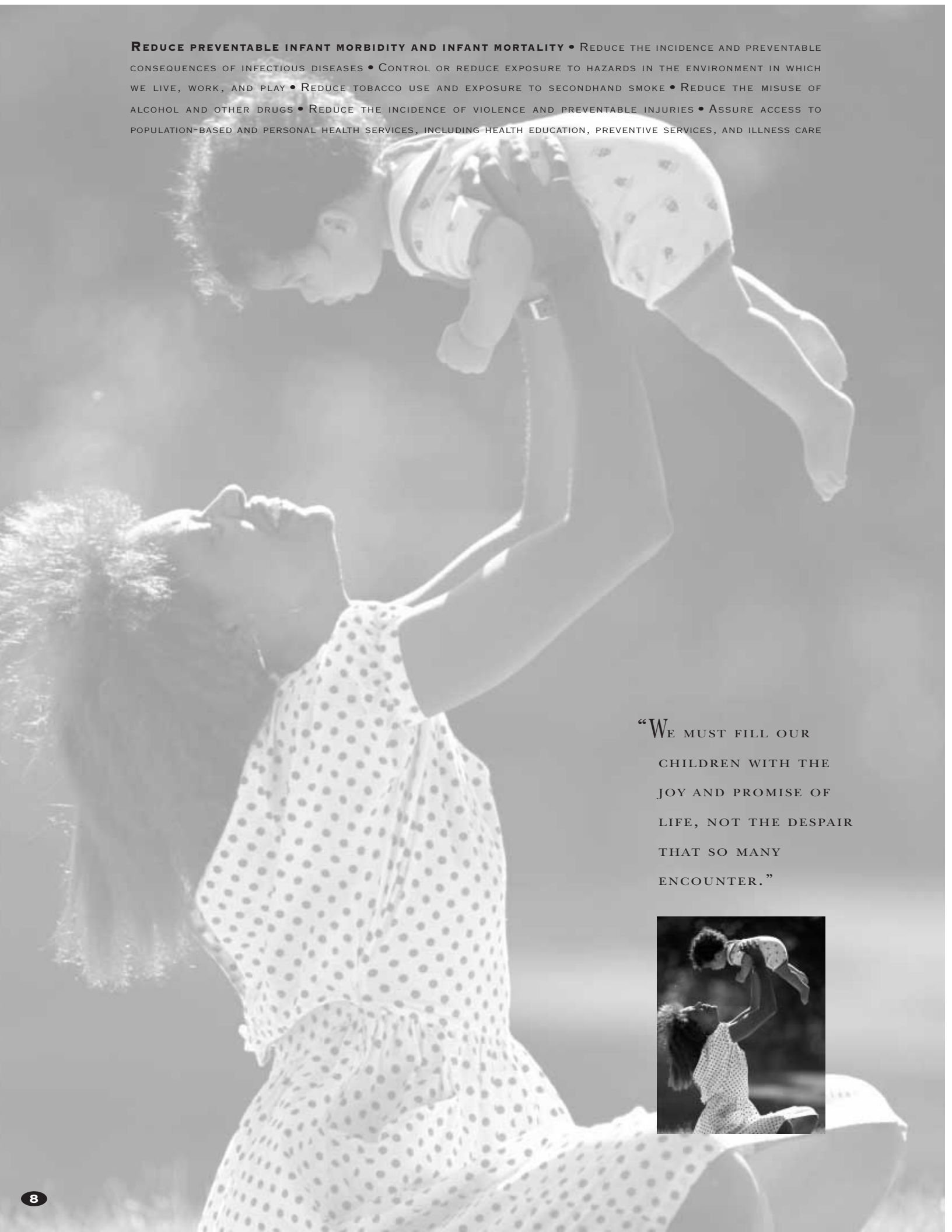
Reduce the misuse of alcohol and other drugs.

Reduce the incidence of violence and preventable injuries.

Assure access to population-based and personal health services, including health education, preventive services, and illness care.

(not in ranked order)

Reduce preventable infant morbidity and infant mortality • Reduce the incidence and preventable consequences of infectious diseases • Control or reduce exposure to hazards in the environment in which we live, work, and play • Reduce tobacco use and exposure to secondhand smoke • Reduce the misuse of alcohol and other drugs • Reduce the incidence of violence and preventable injuries • Assure access to population-based and personal health services, including health education, preventive services, and illness care



"We must fill our children with the joy and promise of life, not the despair that so many encounter."

1

Reduce Preventable Infant Morbidity and Infant Mortality

Recommended Action Strategies for the Washington State Priority Health Goals

Each Action Strategy is numbered and ascribed to a specific state agency for implementation. The State Board of Health recognizes many Action Strategies will require significant interagency coordination and collaboration in working to achieve each State Priority Health Goal. The Board expects to monitor progress made in implementing each Strategy and its effectiveness in moving toward the Goals.

Accountability, Health Efficacy, and Cost Effectiveness: The Public Health Context

The most significant barrier to reducing infant morbidity and mortality is the combination of conditions facing women and families of low socioeconomic status that places them at higher risk of experiencing illness or death of their infants. These conditions include, but are not limited to:

- Lack of financial resources;
- Inadequate housing and nutrition;
- Lack of parenting skills;
- History of domestic violence and child abuse;
- Tobacco, alcohol, and other drug use; and
- Lack of education, job skills, and employment opportunities.

Conditions such as these are particularly acute when faced by teen mothers or single parents. Remediating these problems through public health and other interventions is critical to reducing the risks of infant morbidity and mortality.

Families affected by the combination of conditions are those most likely to require access to comprehensive health and social services needed to reduce infant morbidity and mortality risk. These include: family planning; prenatal care; chemical dependency treatment services designed to meet the special needs of pregnant and parenting women; health and parenting education; mental health services; and other resources necessary for women to gain access to these services such as translation of information into a foreign language, childcare, and transportation. Washington State is a recognized national leader in provision of these services, which

has been increased through legislatively-mandated expansion of Medicaid and the Basic Health Plan. State agencies should strive to continue to provide these services in ways which promote family stability.

Creative strategies are necessary to reach individuals and groups at greatest risk in a timely fashion and with the resources they require most. Programs and services need to be delivered in a culturally-competent manner. Strategies need to be well-directed, outcome-oriented, and address the particular needs of specific racial and ethnic groups.

Society as a whole needs to make a commitment in assuring the health and well-being of all children. While parents and families should be empowered to take primary responsibility for assuring the health and well-being of their children, communities must recognize the compelling reality that many children lack the basic necessities of a safe and nurturing home. A societal commitment to share responsibility and accountability for children's health and well-being will result in comprehensive and far-reaching benefits to all communities in Washington.

Action Strategies

THE WASHINGTON STATE BOARD OF HEALTH recommends the following Action Strategies in moving toward the realization of this Priority Health Goal:

DEPARTMENT OF HEALTH

1.1 Facilitate initiation of infant/child mortality review programs.

1.2 Continue development of a statewide, integrated maternal and infant health information data collection system to track health status of pregnant women and infants.

1.3 Encourage providers of prenatal and well-child care to include infant-oriented injury prevention education to parents.

1.4 Assure confidential access to family planning and other reproductive health services, especially to teens and other at-risk populations. These services should include comprehensive preconception activities for both males and females, including: risk screening; genetic counseling and diagnosis; treatment for sexually transmitted diseases (STDs); nutritional counseling; treatment of tobacco, alcohol, and other drug misuse; and education about maintaining and improving health.

LIQUOR CONTROL BOARD

1.5 Continue active enforcement of requirements for posting of fetal alcohol warning signs in establishments which sell or serve liquor.

OFFICE OF THE SUPERINTENDENT OF PUBLIC INSTRUCTION

1.6 Explore funding sources for school-based and school-linked health centers in confidential settings as requested by local school districts which serve students who are at increased risk for STDs, HIV/AIDS, hepatitis B, and teen pregnancy or who lack access to primary health care and suitable counseling.

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

1.7 Increase state funding and improve coordination among state and local agencies for a wide range of support services for low-income and high-risk families and families with children with special health care needs, including counseling, parenting education, immunizations, lactation instruction and support, WIC, outreach, translation, home visiting services, and transportation and childcare for clients to access these services. (with DOH and HCA)

1.8 Expand the number of culturally-competent, community-based, and prevention-oriented maternal and infant health and social services designed to meet the needs of underserved population groups including racial and ethnic minorities, refugees, adolescents, economically-disadvantaged and/or undereducated individuals, and rural residents. (with DOH and HCA)

1.9 Expand access to appropriate health and social services to newborns affected by alcohol and other drugs, and treatment services to their families. (with DOH)

1.10 Provide incentives for and encourage inclusion of childbirth and parenting education by contractors for Medicaid managed care, Basic Health Plan, and Health Care Authority programs. (with HCA)

1.11 Enhance family planning outreach efforts to increase access to birth control options. (with DOH)

Reduce preventable infant morbidity and infant mortality • **Reduce the incidence and preventable consequences of infectious diseases** • Control or reduce exposure to hazards in the environment in which we live, work, and play • Reduce tobacco use and exposure to secondhand smoke • Reduce the misuse of alcohol and other drugs • Reduce the incidence of violence and preventable injuries • Assure access to population-based and personal health services, including health education, preventive services, and illness care

"Immunization and early treatment for infectious disease are important contributors to our improving health."

2

Reduce the Incidence and Preventable Consequences of Infectious Diseases

Accountability, Health Efficacy, and Cost Effectiveness: The Public Health Context

The spectrum of infectious diseases is changing rapidly in conjunction with dramatic changes in our society. The periodic appearance in the U.S. and Washington of new infections — such as HIV/AIDS, Lyme disease, Legionnaire's disease, *E. coli* 0157:H7, toxic shock syndrome, and hantavirus — and the reemergence of diseases widely presumed to be under control — such as TB and pertussis — demonstrate that complacency about disease prevention and control can be dangerous. New and expanded surveillance, research, and prevention efforts are critical to maintaining a strong defense against infectious diseases that affect, or threaten to affect, public health. A strong public health infrastructure is crucial to ensuring a healthy population.

Without an HIV/AIDS cure in the near future and with the reemergence of other diseases, the primary defense must be general education of the public and targeted education for those at greatest risk. In fact, for all infectious diseases, personal responsibility for behavioral changes is critical to disease prevention. Health efficacy can best be improved by removing impediments which hinder health-promoting behavior. These impediments include cultural, racial, economic, and lifestyle differences that tend to isolate populations, and counter communication efforts. The task is further complicated because many of those infected or at highest risk may be educationally disadvantaged or underserved.

Greater emphasis must be placed on health education: equipping citizens with the tools, skills, and knowledge to protect themselves, their families, and their communities. Comprehensive health education is necessary to put infectious disease prevention into the larger context of healthy behavioral choices, good health and sanitation practices, and appropriate use of health services, including necessary immunizations.

Expansion of the Basic Health Plan and greater commitment to managed care should increase delivery of health care services to a larger proportion of the population. Efforts to control costs through managed care must not be allowed to discourage practitioners from fully utilizing disease prevention strategies such as behavioral risk reduction counseling, sexually transmitted disease screening of at-risk populations, and appropriate adolescent and adult vaccinations. Attention must also be given to immunization outreach endeavors targeted at those least likely to have been contacted by traditional efforts. Timeliness of treatment is also crucial. Treatment services for those affected by infectious diseases are also an important form of prevention. Without treatment, the transmission chain from one infected person to another remains unbroken. In the case of many infectious diseases, those most in need of treatment are among those least able to afford or gain access to health services.

DOH and local health departments/districts require adequate funding to maintain their capacity to respond effectively to an epidemic or outbreak. Population-based services, including contact investigation and follow-up, partner notification services and counseling, and directly-observed therapy for non-compliant TB patients, play an important role in disease prevention.

Accountability can be enhanced through adequate evaluation and follow-up of existing programs. Clinical effectiveness of vaccination is relatively easy to ascertain; tracking the extent of immunization coverage is a greater challenge. Most difficult is evaluating the efficacy of programs directed at effecting long-term, sustainable, behavioral changes. Funding strategies and program design should include adequate monitoring

and evaluation, without which the ability to turn successful pilot projects into more widespread programs can be severely handicapped.

ACTION STRATEGIES

THE WASHINGTON STATE BOARD OF HEALTH recommends the following Action Strategies in moving toward the realization of this Priority Health Goal:

DEPARTMENT OF HEALTH

2.1 Continue development of a coordinated statewide immunization reporting and tracking system.

2.2 Assure availability of vaccines and serums for all persons, regardless of ability to pay. Support the cost of vaccine administration and outreach to at-risk populations.

2.3 Promote repeal of RCW 70.115.050 and 69.50.102(11) to allow sale and distribution of injection drug equipment consistent with sound public health practice.

2.4 Assure availability of latex condoms and instruction on their proper use and effectiveness for the purpose of preventing STDs and HIV infection to at-risk populations including sexually-active teenagers.

2.5 Support local efforts to promote youth access to the means of preventing STDs, pregnancy, and HIV infection, including access to condoms and instruction on their proper use and effectiveness.

2.6 Promote targeted HIV prevention strategies known to be effective in preventing disease transmission, including delaying sexual activity, consistent and correct use of latex condoms, and needle exchange programs.

2.7 Work with the State Board of Health to make hepatitis B carrier status a reportable condition and seek adequate funding to make effective use of the information gained to protect the public's health. (with SBOH)

OFFICE OF THE SUPERINTENDENT OF PUBLIC INSTRUCTION

2.8 Educate school administrators and school boards about the far-reaching health and educational benefits which can be derived from implementation of a comprehensive health education program.

2.9 Provide technical assistance in assessing needs, and designing, implementing, and evaluating effective comprehensive health education programs available to local health departments/districts, community-based organizations, public and private schools, American Indian Tribes, and Bureau of Indian Affairs schools. (with DOH)

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

2.10 Provide timely access to treatment for all people who are clinically diagnosed as chemically dependent to prevent infectious disease transmission. Special attention should be given to programs that treat children, youth, pregnant and parenting women and men, IV drug users, and homeless individuals and families. (with HCA)

2.11 Assure appropriate, affordable, competent, and confidential screening, diagnosis, treatment, counseling, partner notification services, and care for persons with infectious diseases, including STDs, HIV/AIDS, TB, and hepatitis, as part of services available through Medicaid managed care, Basic Health Plan, and Health Care Authority programs. (with HCA)

Reduce preventable infant morbidity and infant mortality • Reduce the incidence and preventable consequences of infectious diseases • **Control or reduce exposure to hazards in the environment in which we live, work, and play** • Reduce tobacco use and exposure to secondhand smoke • Reduce the misuse of alcohol and other drugs • Reduce the incidence of violence and preventable injuries • Assure access to population-based and personal health services, including health education, preventive services, and illness care

"The more people understand their environment and disease prevention, the better equipped they are to take responsibility for protecting and maintaining their own health."

3

Control or Reduce Exposure to Hazards in the Environment in Which We Live, Work, and Play

Accountability, Health Efficacy, and Cost Effectiveness: The Public Health Context

Washington residents enjoy a high quality of life, due in large part to the environment in which we live, work, and play. A combination of population growth, increased industrial production and use of toxic products and byproducts, and increased automobile use place this quality of life and our health at risk. Diligent ongoing efforts are crucial to adequately protect our air and water and safeguard residents from hazards in homes, schools and daycare, restaurants, and workplaces.

Difficult challenges for environmental health stem from the actual and potential harmful effects of microbial agents and hazardous substances. While exposure to toxic agents can be reduced, or their impacts controlled, pollution prevention is the most efficient and cost-effective means of safeguarding the health of Washington residents. This will require long-term changes in individual habits and industrial methods of waste generation and disposal, as well as other fundamental changes in production and consumption practices.

Lack of education, insufficient public awareness and commitment, and economic and cultural factors are among the most important obstacles to effective action. The more people understand their environment and disease prevention, the better equipped they are to take personal responsibility in protecting and maintaining their own health.

Concerted efforts are needed to improve coordination among local, state, and federal agencies to control or reduce exposure to environmental hazards. Building assessment capacity and comprehensive ongoing hazard identification and monitoring efforts are critical to understanding environmental challenges and evaluating the effectiveness of prevention and intervention strategies. State and local governments also have pivotal roles to play in providing information to the public and technical assistance to business and industry to ensure the quality of Washington's environment today and for future generations.

Action Strategies

The Washington State Board of Health recommends the following Action Strategies in moving toward the realization of this Priority Health Goal:

Air Quality

Department of Ecology

3.1 Attain federal air quality standards in Washington's non-attainment areas.

3.2 Expand use of environmental indicators to track air quality trends and measure success.

3.3 Provide technical assistance and education materials to enable communities to take action to reduce exposure to outdoor air pollutants.

3.4 Expand technical assistance to local air quality authorities and local health departments/districts to improve their air quality monitoring and health advisory systems. (with DOH)

Department of Health

3.5 Provide assistance to local health departments/districts to work with local school districts to improve school indoor air quality.

3.6 Explore feasibility of developing pediatric indoor air quality standards.

WATER QUALITY

DEPARTMENT OF AGRICULTURE

3.7 Continue to develop guidelines through state and federal agricultural agencies to control possible agricultural pollution sources such as cropland erosion, animal waste, pesticides, fertilizer losses, and contaminated irrigation water.

3.8 Develop alternative methods to control agricultural water pollution sources such as erosion, animal waste, pesticides usage, improper use of fertilizer, agricultural run-off, and irrigation water.

DEPARTMENT OF ECOLOGY

3.9 Develop, support, and promote implementation of a comprehensive statewide wastewater and stormwater management program.

3.10 Ensure future availability of safe drinking water through groundwater protection, local wellhead and watershed protection programs, water resource management activities, and water reclamation. (with DOH)

3.11 Implement a comprehensive groundwater protection program for identification of critical aquifer recharge areas that includes monitoring groundwater quality, developing a database, and undertaking research on soil quality and other important hydrogeologic features.

3.12 Implement a watershed-based wastewater discharge pollution control program.

3.13 Continue the development of the Comprehensive State Groundwater Protection Program and encourage continued participation in the Interagency Groundwater Committee by all affected state and federal agencies.

3.14 Explore and develop strategies by which nitrate loading from large onsite sewage systems can be reduced.

DEPARTMENT OF HEALTH

3.15 Promote capacity of state and local health departments/districts to fully implement regulations and monitor design, installation, and operation of onsite wastewater systems.

3.16 Assure primacy for the administration and future implementation of drinking water programs.

FOODBORNE ILLNESS

DEPARTMENT OF HEALTH

3.17 Assist local health departments/districts in developing food service manager training programs and production of multilingual food service worker training videos and materials.

OFFICE OF THE SUPERINTENDENT OF PUBLIC INSTRUCTION

3.18 Increase capacity of the Office of the Superintendent of Public Instruction and local health departments/districts to educate children in grades pre-K-12 about health hazards resulting from improper food preparation and handling and on the importance of personal hygiene and handwashing.

HAZARDOUS MATERIALS

DEPARTMENT OF AGRICULTURE

3.19 Continue and expand multilingual programs to educate farmworkers, employers, applicators, and residents about pesticide risks and protective measures.

DEPARTMENT OF ECOLOGY

3.20 Strengthen the relationship and increase funding levels for hazardous waste management activities where state and local governments have or share responsibilities.

3.21 Educate the public, businesses, and state agencies about pollution prevention efforts, including toxic substance use reduction and product substitution in basic household and custodial cleaning.

3.22 Develop a vocational/technical school curriculum focusing on the proper use of hazardous substances, exploring safer alternatives, and proper disposal of hazardous wastes on the job. Provide technical assistance to school personnel on hazardous substance and hazardous waste management.

Work Environment

Department of Labor & Industries

3.23 Increase in-service training and continuing education of clinicians in identification, diagnosis, and treatment of occupational illnesses.

3.24 Increase emphasis on surveillance, risk assessment, early intervention, and implementation of agricultural worker protection standards.

3.25 Establish a program to monitor cholinesterase (an enzyme) to protect pesticide handlers.

3.26 Support risk reduction in the workplace by developing and implementing incentives and methods to increase employer-employee participation in reducing occupational injury and illness, including those resulting from exposure to toxic materials, including pesticides.

3.27 Provide technical assistance to small businesses in implementing work-related injury and illness prevention and wellness programs.

School Environment

Department of Health

3.28 Encourage use of less toxic or non-toxic cleaning agents, solvents, and paint products in the school environment. (with Ecology)

3.29 Increase availability of provider and staff training and training materials on health and safety issues through childcare resource and referral agencies statewide. (with DSHS)

3.30 Encourage implementation of federally-mandated Chemical Hygiene Plans in local school districts.

Office of the Superintendent of Public Instruction

3.31 Seek adequate funding to monitor occurrences of health hazards and injuries to students and staff in schools, school environments, and playgrounds, and to implement prevention programs. (with DOH)

Department of Social and Health Services

3.32 Seek adequate state funding to institute at least yearly monitoring of childcare facilities.

Temporary Worker Housing

Department of Community, Trade & Economic Development

3.33 Support pre-development funding for provision of additional temporary farmworker housing.

Disaster Preparedness

Department of Community, Trade & Economic Development

3.34 Promote use of the Growth Management Act and state building codes to ensure residential, business, and public facility construction is not permitted in hazardous areas including flood plains and areas subject to seismic hazards.

Department of the Military

3.35 Promote mitigation of, preparedness to respond to, and recovery from emergencies and disasters.

Reduce preventable infant morbidity and infant mortality • Reduce the incidence and preventable consequences of infectious diseases • Control or reduce exposure to hazards in the environment in which we live, work, and play • **Reduce tobacco use and exposure to secondhand smoke** • Reduce the misuse of alcohol and other drugs • Reduce the incidence of violence and preventable injuries • Assure access to population-based and personal health services, including health education, preventive services, and illness care

"Smoking is the single most important preventable cause of death."

4

Reduce Tobacco Use and Exposure to Secondhand Smoke

Accountability, Health Efficacy, and Cost Effectiveness: The Public Health Context

Tobacco use is the leading preventable cause of death in the U.S. and in Washington. Tobacco is virtually the only consumer product which, when used as recommended by the manufacturer, directly results in addiction, disease, disability, and death. Yet, the amount of money spent on advertising this highly addictive product, more than $6 billion annually, goes unchecked and appears to be aimed specifically at vulnerable populations, including: young children, women, racial and ethnic minorities, and teens. The Federal Trade Commission reports, "Cigarettes are the most heavily advertised product in America." Advertising directed at teenagers and which glamorizes and legitimizes tobacco use is particularly insidious, as sale of tobacco products in Washington to those under age 18 is illegal. Tobacco product manufacturers carefully tailor their advertising strategies to create the false impression that tobacco use poses no significant health risks and to assure a continuous stream of new consumers to replace those who die from use of the product.

Washington residents have a clear, significant, and tangible stake in reducing prevalence of tobacco use. Medical costs associated with smoking, if saved and redirected, could provide health care subsidies for virtually every low-income resident of Washington, reduce health insurance costs for all, and improve the quality of life of thousands of people. Without substantial efforts to reduce prevalence of tobacco use, all Washington residents — smokers and nonsmokers alike — remain saddled with an enormous resource drain on the health system and on the economy as a whole.

Addicted tobacco users require compassion and opportunities to change. Tobacco cessation programs need to be widely available; easily accessible; designed to deal with the denial common among chemically-dependent individuals; and efficacious. Efficacy of various approaches should be documented. Community leaders, health care providers, local and state agencies, and employers all have a significant role to play in ensuring individuals' access to treatment for their addiction. As with all addictions, individuals need to take responsibility for their own health and well-being in effecting behavioral changes.

Prevention activities aimed at changing public consciousness about tobacco use need to be well-planned, adequately funded, and critically evaluated. Influencing behavioral changes, especially among young people is often difficult when the consequences are long-term and not readily perceived. Anti-tobacco education and prevention efforts must reach children and youth before they begin using tobacco products, especially to counter messages already being delivered to them through the media. Strict enforcement of laws and ordinances limiting youth access to tobacco, coupled with sure application of penalties, can play a crucial role in prevention.

ACTION STRATEGIES

THE WASHINGTON STATE BOARD OF HEALTH recommends the following Action Strategies in moving toward the realization of this Priority Health Goal:

LIQUOR CONTROL BOARD

4.1 Propose additional personnel and funding to assure effective enforcement of laws prohibiting tobacco sales to minors.

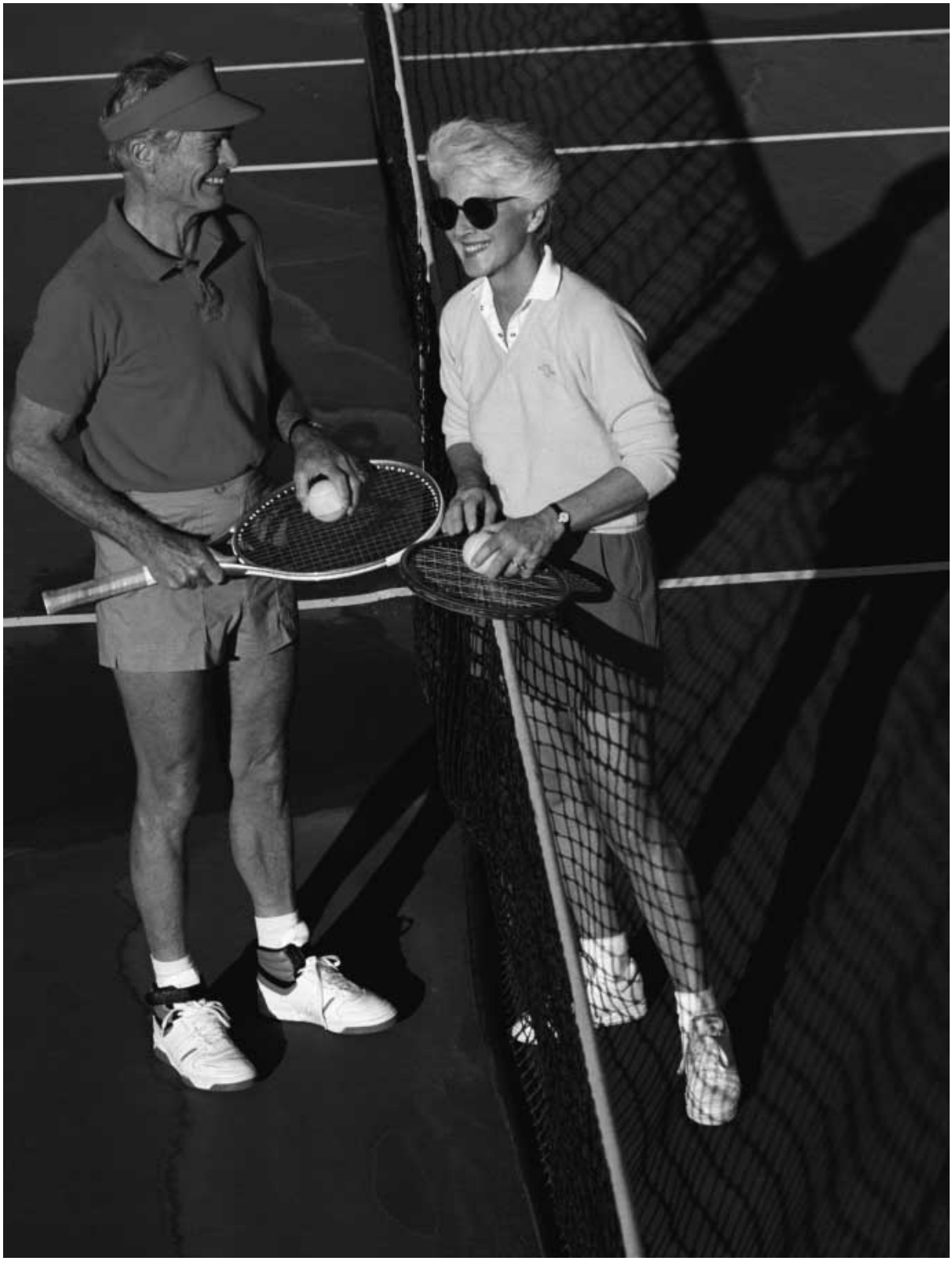
4.2 Propose legislation to prohibit sampling and sale or provision of tobacco products through the mail.

OFFICE OF THE SUPERINTENDENT OF PUBLIC INSTRUCTION

4.3 Support and/or enhance local school district tobacco, alcohol, and other substance misuse K-12 education curricula, with emphasis on a strong tobacco prevention/education message.

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

4.4 Provide incentives and encourage contractors to offer tobacco cessation treatment programs through Medicaid managed care, Basic Health Plan, and Health Care Authority programs. (with HCA)



Reduce preventable infant morbidity and infant mortality • Reduce the incidence and preventable consequences of infectious diseases • Control or reduce exposure to hazards in the environment in which we live, work, and play • Reduce tobacco use and exposure to secondhand smoke • **Reduce the misuse of alcohol and other drugs** • Reduce the incidence of violence and preventable injuries • Assure access to population-based and personal health services, including health education, preventive services, and illness care

"The misuse of alcohol and other drugs harms health, family life, the economy, and public safety, and affects all segments of society."

5

Reduce the Misuse of Alcohol and Other Drugs

Accountability, Health Efficacy, and Cost Effectiveness: The Public Health Context

Although alcohol misuse results in a substantially higher incidence of adverse consequences to public health and safety than misuse of other drugs, there appears to be a broad cultural acceptance of alcohol use and greater focus given to the misuse of other drugs as an area of concern. Refocusing public attention on alcohol misuse as having the greater impact on public health may significantly aid efforts in combatting it.

Cultural acceptance of alcohol is constantly reinforced by advertising that glamorizes use by relating alcohol to sex, fun, wealth, and popularity. Such glamorization not only bolsters cultural acceptance of alcohol misuse, but particularly impacts adolescents' attitudes and behaviors. Prevention efforts in family, school, community, and other settings must include effective methods of countering this advertising.

The misuse of alcohol and other drugs is a family issue. A recent national survey indicates some 43% of U.S. adults have been exposed to alcoholism in the family. More than 20% of Washington families have at least one member who misuses alcohol or other drugs. Nearly 1/3 of infants born to Washington women who misuse alcohol or other drugs during pregnancy are referred to Child Protective Services before age 2. Recent studies indicate fetal alcohol syndrome and fetal alcohol effects are the most common birth defects in Washington.

Of critical concern is finding a proper balance in use of public funds between community-based primary prevention efforts and treatment. While preventing alcohol and other drug misuse problems before they begin should be a high priority, effective treatment of chemically-dependent individuals also holds the promise of substantially reducing other health, social service, and crime-related costs.

Chemical dependency can only be reduced by individuals taking responsibility for their own health. A barrier to reducing chemical dependency is the denial aspect of the disease. Individuals who misuse alcohol or other drugs or are chemically dependent are often unaware or unable to accept that they have this disease. Additionally, individuals suffering from chemical dependency are not given the same attention or compassion as individuals who suffer from other diseases, and there are social stigmas attached to receiving treatment. Health care providers often are not well-trained in screening and diagnosing chemically-dependent patients.

As Washington's health system continues to evolve, adherence to several key principles is likely to result in increased accountability, efficacy, and cost effectiveness:

- Chemical dependency treatment services are basic medical care. Providing appropriate chemical dependency treatment is preventive of other health conditions and will result in lower overall health care costs. Early intervention will result in greater cost savings.
- Provision of adequately-funded, community-based alcohol and drug misuse prevention and education, including programs that reduce risks and enhance protective factors, should be assured for all residents as a basic public health service.
- Since a significant proportion of those receiving medical care or who are hospitalized have a secondary or tertiary chemical dependency diagnosis, provision of chemical dependency services should be an integral part of the health care delivery system.

- A managed continuum of treatment, with due regard for ethnic and gender diversity, should be available through health plans. The continuum should include: screening; assessment and diagnosis; inpatient and outpatient treatment; intermediate and continuing care services; and case-managed linkages with other community resources.
- Appropriate support services should be available for family members of chemically-dependent persons.
- There should be required training for primary health care providers in assessment and diagnosis of chemical dependency, and protocols for referral to appropriate treatment.
- Quality assurance measures for chemical dependency treatment should be implemented where possible.
- Reducing the prevalence of alcohol and drug misuse is not the only priority. Establishing "harm reduction" as an objective — through promotion of opiate substitution programs, "drug courts" which offer treatment as an alternative to incarceration, and other innovative strategies — has potential for significant benefit to the health of individuals and communities.

Action Strategies

The Washington State Board of Health recommends the following Action Strategies in moving toward the realization of this Priority Health Goal:

Department of Corrections

5.1 Increase the availability of, and provide funding for, chemical dependency treatment in correctional institutions, especially including juvenile corrections facilities. (with DSHS)

5.2 Explore feasibility of providing discharge planning and referral to appropriate community-based chemical dependency treatment services. (with DSHS)

Office of the Insurance Commissioner

5.3 Explore feasibility of requiring provision of outpatient treatment for chemical dependency in all Medicare supplement plans.

Liquor Control Board

5.4 Maintain strict enforcement laws prohibiting commercial establishments from selling or serving alcohol to those under twenty-one years-of-age.

Department of Social and Health Services

5.5 Support research and evaluation efforts designed to determine the most effective and cost-efficient chemical dependency treatment strategies.

5.6 Provide stable funding for population-based prevention services used to: identify research-based risk indicators and collect data to support risk-factor analysis of individuals, families, and communities; and mobilize communities and seek community input in response to risk indicators.

5.7 Encourage and support increased collaboration both within and between state agencies and with local resources to treat chemically-dependent adolescents who are served by multiple agencies/divisions, especially those residing in or transitioning from, out-of-home placements.

5.8 Support development of linkages among local school districts, county prevention agencies, and local health departments/districts to improve delivery of population- and community-based services to prevent alcohol and other drug misuse.

5.9 Coordinate resources among various state agencies to support local communities in implementing initiatives targeted at high-risk youth. Use existing youth groups to reach this audience when possible.

5.10 Conduct alcohol and other drug misuse prevention activities aimed at reaching preschool-aged children, through preschool cooperatives, early childhood education programs, childcare services, parenting programs, and other community-based services. (with OSPI)

5.11 Increase accessibility and availability of chemical dependency treatment for adolescents which also addresses their mental health and developmental problems.

5.12 Increase accessibility and capacity of chemical dependency treatment services and after-care support programs for women. Expand access for pregnant and parenting women, including residential treatment programs which can accommodate their children with them.

5.13 Provide substance misuse prevention services to children of chemically-dependent parents, who are at high risk for alcohol and other drug misuse problems in adolescence and adulthood.

5.14 Provide childcare services for parents to enable them to make use of treatment services.

5.15 Provide diagnostic and developmental services for infants and children affected prenatally by maternal alcohol or drug use to help them function effectively in school and other settings.

5.16 Support business-initiated efforts to develop alcohol and other drug misuse prevention and treatment strategies in the workplace. Encourage and provide incentives to self-insured employers to provide chemical dependency treatment and after-care support coverage for their employees.

5.17 Provide a managed continuum of care, with due regard for ethnic and gender diversity, through Medicaid, Basic Health Plan, and Health Care Authority programs. Continuum should include: screening, assessment and diagnosis; inpatient and outpatient treatment; intermediate and continuing care services and case-managed linkages with other community resources. (with HCA)

5.18 Explore feasibility of including individual and group counseling services to family members of chemically-dependent persons among services available through Medicaid, Basic Health Plan, and Health Care Authority programs to facilitate family adjustment and reinforce recovery. (with HCA)

5.19 Support culturally-appropriate outreach programs that provide information about available resources to substance-misusing pregnant women.

5.20 Document the need and develop strategies to address alcohol and other drug misuse among seniors.

5.21 Establish a statewide alcohol and other drug clearinghouse for use by the general public.

5.22 Develop and disseminate appropriate alcohol and other drug misuse prevention information targeting college/university/vocational and technical school students.

5.23 Continue to increase accessibility and availability of safe and sober housing options for adults, including parents with young children, in recovery from chemical dependency.

5.24 Develop alcohol and other drug prevention materials to be used by persons who are hearing or visually impaired, have traumatic brain injuries, or are developmentally delayed.

5.25 Support the development of Fetal Alcohol Syndrome screening clinics on a statewide basis.

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"We face the challenge of keeping our families safe in a world that has already taken too many lives and irreparably damaged countless others."

6

Reduce the Incidence of Violence and Preventable Injuries

Accountability, Health Efficacy, and Cost Effectiveness: The Public Health Context

The task of injury prevention and control is to limit opportunity for injuries to occur and minimize consequences when they do occur. The most successful approaches to reducing the incidence of injuries and violence involve a combination of strategies to promote behavioral changes through education, legislation, application of new technology including modification of the environment, and regulation enforcement.

Injuries and violence do not occur by chance. They are understandable, predictable, and preventable. There are known risks for injuries and violence, and these risks can be reduced. Risk reduction requires substantial investments in infrastructure — safer highways, better housing — as well as emergency response agencies, domestic violence shelters, dispute resolution programs, youth education, youth centers, alcohol and drug misuse prevention and treatment programs, counseling services for victims of child abuse and sexual assault, and job training. The price for not adequately providing such investment can be measured in short- and long-term increases in health care costs, higher crime rates, loss of life, damage to children, lower community morale, economic losses, and reduced quality of life for individuals, families, communities, and the State as a whole.

Public health approaches to injury and violence prevention require adequate reporting and data-gathering systems. Especially in the area of violence prevention, investment in improved data systems will result in greater accountability, allowing for better targeting of at-risk populations and evaluation of various strategic approaches.

Action Strategies

The Washington State Board of Health recommends the following Action Strategies in moving toward the realization of this Priority Health Goal:

Department of Health

6.1 Provide educational materials for emergency room and ambulance personnel on identification of injuries resulting from domestic violence and child abuse and neglect.

6.2 Improve coordination between Departments of Health, Social and Health Services, Community, Trade & Economic Development, Washington State Patrol, Washington Traffic Safety Commission, Office of the Superintendent of Public Instruction (OSPI), and other state and private agencies in collecting and sharing data, determining critical prevention issues, and developing injury prevention programs. (with other agencies)

6.3 Provide culturally-appropriate information on domestic violence and sexual assault.

Department of Labor & Industries

6.4 Track and analyze workplace injuries and injury claims due to violence. Target prevention activities toward high-risk industries and occupations.

6.5 Complete long-term disability prevention pilot studies in Everett and Yakima.

Department of Social and Health Services

6.6 Support systems for coordinated data collection relating to all cases of domestic violence, sexual assault, and child abuse. Systems should require

information from law enforcement officials, hospital emergency rooms, health care and social service providers, and teachers.

6.7 Educate seniors and their caregivers about the importance of exercise and safe, sturdy footwear in preventing falls, and on the commonly-used drugs whose side effects increase risks of falls. Coordinate such efforts with home health agencies and Area Agencies on Aging.

6.8 Ensure stable funding for safe emergency and transitional housing for victims of domestic violence and their children.

6.9 Provide comprehensive evaluation and treatment services for young and first-time perpetrators of sexual assault, molestation, and other domestic violence.

6.10 Increase capacity to serve and support families who are in crisis and/or at risk of child abuse or neglect with use of family support services, family preservation services, and individualized and tailored treatment plans.

6.11 Guarantee the health and safety of children in out-of-home placement by increased support and monitoring of residential resources and improved quality assurance measures.

6.12 Provide for improved emotional well-being and physical health of children by shortening lengths-of-stay in out-of-home care and achieving a permanent plan as quickly as possible for children unable to return to their homes.

6.13 Provide stable funding for legal advocacy for victims of domestic violence.

WASHINGTON TRAFFIC SAFETY COMMISSION

6.14 Propose legislation to set up a system of provisional or graduated licensing to reduce the incidence of motor vehicle injuries among novice drivers.

6.15 Continue implementation of campaigns to reduce drinking and driving, and increase seatbelt use.

6.16 Continue to educate the public about correct installation and use of approved safety restraints in motor vehicles for both children and adults.

STATE BOARD OF HEALTH

6.17 Work to decrease the incidence of gun-related injuries and death through statewide coordinated strategies including the following elements:

- Accurate and ongoing assessment of gun-related trauma through mandatory reporting of injuries by medical care providers;
- Development and monitoring of health status indicators tracking the impact of gun-related trauma on youth violence, domestic violence, substance misuse, medical care expenditures, and criminal justice system costs;
- Promotion of educational strategies that instruct students about the health consequences of firearm use and the general public on harm reduction strategies designed to increase firearm safety and decrease minors' access to firearms;
- Advocacy of selective enactment and rigorous enforcement of regulatory efforts to limit access to firearms by youth and adults who are not prepared to use them safely and responsibly;
- Requirements that firearm purchasers show proof of adequate liability insurance for firearm injuries prior to purchase and that firearm sellers be held liable under civil statutes for damages resulting from firearm use by an unqualified purchaser;
- Amendment of the state preemption of gun ordinances to allow political jurisdictions to enact ordinances in keeping with local community values likely to be effective in curbing gun-related injuries.

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"The responsibility for personal health ultimately lies with individuals. Being able to fulfill that responsibility requires us to make informed choices."

7

Assure Access to Population-Based and Personal Health Services, Including Health Education, Preventive Services, and Illness Care

Accountability, Health Efficacy, and Cost Effectiveness: The Public Health Context

Through legislation enacted in 1995, Washington has taken major steps to ensure residents have access to health care services. Subsidized Basic Health Plan enrollment will be expanded to enroll 200,000 adults by July 1997. Medicaid will enroll up to 130,000 low-income children whose families earn between 100-200% of the federal poverty level to receive free medical and preventive dental care. Taken together, these efforts will result in about half of Washington's uninsured population receiving health insurance, many for the first time.

Washington is a national leader in guaranteeing availability, continuation, and portability of insurance benefits, in the use of community rating in setting rates, and in limits placed on waiting periods for pre-existing conditions. Through these reforms, Washington has provided individuals, families, and businesses with a health care safety net. Much work remains to be done to ensure these reforms have the desired result. Outreach to low-income, minority, and rural communities will be essential to ensuring access.

The Legislature also took significant steps to further interagency coordination and collaboration in ensuring the quality of care. The new Health Care Policy Board (HCPB) is working to coordinate quality assurance activities with the Departments of Health (DOH), Labor & Industries, Social and Health Services, Health Care Authority, and Office of the Insurance Commissioner. In addition, DOH, in consultation with HCPB and with consumers, health insurers, and providers, is studying the feasibility of a uniform quality assurance and improvement program. Together, these cooperative efforts are vital to ensuring accountability and cost effectiveness throughout the health care system.

The first Public Health Improvement Plan (PHIP) was also approved by the Legislature. It is legislative intent to initiate a program to provide the public health system with the necessary capacity to improve health outcomes, and establish a methodology by which to assess improvement in these outcomes and public health service delivery. Implementation of PHIP by DOH and Washington's 33 local health departments/districts will be an important step in carrying out the mission of public health in assuring conditions in which people can be healthy. The State Board of Health plans to support ongoing PHIP activities and anticipates being an active partner in the development of future Plans.

As health insurance access is expanded, and public health's capacity to carry out its mission assured, the need to provide improved health education becomes more important. The responsibility for personal health ultimately lies with individuals themselves. Being able to fulfill that responsibility is dependent upon people being sufficiently educated to make informed choices in pursuit of positive health outcomes. State and local health agencies, in cooperation with families, schools, and communities, must together find ways to provide information which motivate individuals to make appropriate medical care decisions and health-promoting behavioral changes.

Action Strategies

The Washington State Board of Health recommends the following Action Strategies in moving toward the realization of this Priority Health Goal:

Department of Health

7.1 Develop more effective ways to measure outcomes, efficacy, and cost effectiveness of prevention activities and treatments provided by the full

range of state-regulated health care practitioners, including registered nurses, midwives, advanced registered nurse practitioners, physicians assistants, massage therapists, physical and occupational therapists, naturopaths, acupuncturists, and dental hygienists.

7.2 Eliminate or modify regulations which create unnecessary barriers to access or which discourage equitable supply and distribution of qualified health personnel.

7.3 Assure health service delivery to rural residents by:

- Supporting community-based initiatives which effectively respond to local needs, conditions, and circumstances;
- Promoting health system development as a standard consideration of rural economic development and revitalization initiatives;
- Encouraging enrollment in the Basic Health Plan and Medical Assistance programs; and
- Assisting rural residents in accessing local providers.

7.4 Work with the Office of the Superintendent of Public Instruction to improve education of school personnel and school boards regarding children's dental health risks and the effectiveness of various school-based intervention strategies (e.g., self-applied fluoride and dental sealant programs). (with OSPI)

HEALTH CARE AUTHORITY

7.5 Continue to increase access to affordable health care through the Basic Health Plan. Evaluate, and, if necessary, make further adjustments to subsidy levels; increase awareness of the program through community outreach and marketing; and continue to expand the number of available avenues for enrolling individuals and employer groups (i.e., brokers, agents, provider contacts).

7.6 Encourage preventive care by continuing to design benefit structures with appropriate incentives such as well-child exams and periodic adult physicals.

7.7 Investigate ways of providing consumers with decisionmaking tools which help them choose health care plans that fit their needs.

7.8 Design a risk-adjustment mechanism that distributes payments to managed care plans based on the risk of their enrollees, encouraging the best care for any type of condition or patient without fear of financial disadvantage.

OFFICE OF THE INSURANCE COMMISSIONER

7.9 Expand educational programs which enable residents and businesses to become better informed purchasers and consumers of health services.

DEPARTMENT OF LABOR & INDUSTRIES

7.10 Conduct outcomes research on key medical and surgical interventions for injured workers and develop treatment guidelines for these conditions to improve outcomes.

OFFICE OF THE SUPERINTENDENT OF PUBLIC INSTRUCTION

7.11 Encourage provision of school-based and school-linked health services.

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

7.12 Explore feasibility of including dental care among services available through Medicaid managed care and the Basic Health Plan. (with HCA)

7.13 Continue to develop a system of long-term care which provides a comprehensive range of

services provided in the least restrictive setting, to include: in-home assistance, protective supervision, community and out-of-home residential services, full range of supportive housing options, access to public transportation, and rehabilitation services.

7.14 Continue and expand efforts to assure full participation of consumers, family members, and advocates in management and delivery of mental health services. (with HCA)

7.15 Address the special health care needs, including the need for mental health care services, of people: with developmental disabilities; multiple disabilities; who require medically-intensive services; or have "cross system" needs, such as mentally ill seniors and children.

7.16 Continue development of efficient and effective regionally-based, managed-care mental health systems which provide continuous care for people with serious and chronic mental illness.

7.17 Provide incentives for and encourage inclusion of childbirth and parenting education by contractors for Medicaid managed care, Basic Health Plan, and Health Care Authority programs. (with HCA)

7.18 Expand availability of culturally-appropriate mental health, chemical dependency treatment, and other services addressing the unique needs of diverse populations including African Americans, Hispanics, Asian Americans, American Indians, people with different sexual orientations, and refugees. Ensure inclusion of pediatric mental health services available through Medicaid, Basic Health Plan, and Health Care Authority programs. (with HCA)

7.19 Educate citizens covered by Medicaid, Basic Health Plan, and Health Care Authority programs about availability of mental health services to individuals in crisis. Education should include efforts to destigmatize mental illness, alcoholism, and drug addiction to encourage individuals to seek help when needed. (with HCA)

7.20 Work with the Department of Health, providers, and appropriate consumer advocates to strategize and implement procedures to train or retrain health care providers so they are better prepared to work with culturally and socially diverse populations, persons with serious and chronic mental illness, chemical dependency, and individuals with developmental disabilities or multiple disabilities or who are homeless. (with DOH)

7.21 Explore feasibility of setting up community benefits liaisons to perform outreach and provide education and enrollment assistance to culturally diverse, physically challenged, or difficult-to-reach populations.

7.22 Develop model contract language for all state purchasers of health care for low-income residents that helps eliminate barriers to care by ensuring all contracting plans have networks with necessary local support services, such as outreach, translation, and transportation. (with HCA and OIC)

7.23 Explore use of new data tools to more efficiently track and monitor outcomes, efficacy, and client satisfaction. (with DOH, HCA)

7.24 Develop a diagnosis-specific client registry to identify which Social Security Insurance clients receive what services from the Department of Social and Health Services to improve overall case management.

7.25 Ensure cooperative and collaborative government-to-government relationships in delivery of health services to American Indians which recognize the sovereignty of tribal governments.

7.26 Develop Basic Health Plan referral materials and strategies to market health care coverage for low-income children, families, and individuals. (with HCA)

The Legislature Acts and State Agencies Respond

"The Legislature Acts" and "State Agencies Respond" sections of the *1996 Washington State Public Health Report* showcase the efforts of the eight state health care agencies as designated in RCW 43.20.050(1)(b) and the Legislature directed at achieving the State Priority Health Goals. Included are highlights regarding legislation enacted during the 1995 Session and new or expanded initiatives undertaken by state agencies since publication of the *1994 Report.*

Reduce Preventable Infant Morbidity and Infant Mortality

State Agencies Respond

Following passage of ESHB1408 in 1993, the Department of Health (DOH) launched a statewide media campaign titled "Teen Aware". During the 1994-95 school year, 24 schools from 23 school districts participated in developing the campaign promoting sexual abstinence. Students were involved in researching, developing, producing, and disseminating products, including: posters; print advertising; T-shirts; video and radio productions; buttons; and theatrical performances. Funds were appropriated during the 1995 Legislative Session to continue the campaign.

As required by SHB1035 enacted in 1995, DOH, in collaboration with the Department of Social and Health Services (DSHS), local health jurisdictions, coroners, and medical examiners, completed development of a consistent review process for all unexpected deaths of minors receiving child welfare services from DSHS.

In July 1995, DSHS Medical Assistance Administration initiated a statewide family planning outreach effort utilizing bus posters to reach 80% of the state's population. The posters have a family planning/birth control message and toll-free number for individuals to access services. Family planning nurses have been placed in community service offices to assist client access to birth control information and services.

Reduce the Incidence and Preventable Consequences of Infectious Diseases

State Agencies Respond

In 1994, the Office of the Superintendent of Public Instruction (OSPI) surveyed schools regarding the state of comprehensive health education and provision of HIV/STD education. More than 60% of school districts now require one health education course in high school, which usually includes information on HIV/STDs.

OSPI completed a revision of the state model *KNOW: HIV/STD Prevention Curriculum* for grades 5-12 in 1995. In cooperation with Seattle Public Schools, OSPI developed a video on STDs titled *Take Charge: Managing Your Sexual Health* which is available to all schools and local health departments/districts.

Control or Reduce Exposure to Hazards in the Environment in Which We Live, Work, and Play

The Legislature Acts

SSB5606 removes barriers to reuse of wastewater by providing a mechanism for financial assistance to reclaimed water facilities; recognizing and encouraging additional beneficial uses of reclaimed water for recharge and maintenance of wetlands; and clarifying existing policies. The Department of Ecology, in consultation with the Department of Health (DOH), is required to adopt standards for direct recharge using reclaimed water and for discharge of reclaimed water into natural wetlands.

The Legislature passed E2SSB5448 to improve operation and management of small drinking water systems, clarify coordinated water system planning processes and responsibilities, and enhance local government decisionmaking.

ESB5998 establishes a process whereby local health officers can waive State Board of Health rules for onsite sewage systems on a site-by-site basis. Waivers granted must be consistent with state standards and their intent. DOH is to review waivers granted on a quarterly basis and provide technical assistance to correct problems.

Passage of SHB1404 brings DOH's shellfish sanitation program into closer conformity with U.S. Food and Drug Administration standards. DOH is authorized to conduct administrative searches and to close, by administrative order, commercial or recreational harvest of any marine species if a public health threat is found to exist.

The Legislature passed SSB5315, requiring licensing of food storage warehouses and exempts warehouses inspected by approved sanitation consultants. Refrigeration requirements for distributors and retailers of eggs are established, and statutes amended to meet current industry and program enforcement needs.

ESSB5303 designates DOH as the single state agency responsible for encouraging development of additional temporary worker housing. DOH is responsible for coordinating the activities of state and local agencies to assure a seamless, nonduplicative system for housing development and operation. The Department of Community, Trade & Economic Development is directed to contract with nonprofit corporations to provide technical assistance to individuals or organizations seeking to construct housing for farmworkers.

State Agencies Respond

The Department of Ecology (Ecology) published a report "Washington's Environmental Health 1995". Through the use of environmental indicators, the report provides a statewide assessment of the health of Washington's air and water and generation of solid and hazardous waste. Ecology is continuing to refine the indicators and will publish a second report in Fall 1996.

Ecology created a "Risk Assessment Forum" to focus attention across program lines on risk issues, thereby strengthening databases and regulatory consistency. Activities are being shifted to a geographic basis, allowing priority health risks in a specific area to be addressed more directly by all programs. Groundwater protection, monitoring, and assessment have been expanding.

Since 1991, Ecology has adopted or refined technical assistance, educational, and regulatory strategies to clean up outdoor air in 13 areas violating federal air quality standards for carbon monoxide, ozone, and particulates in King, Pierce, Thurston, Snohomish, Yakima, Spokane, Walla Walla, and Clark Counties. Ecology's Air Quality Program, in conjunction with local air quality authorities, completed cleanup plans and instituted cost-effective pollution reduction strategies in all 13 areas; 11 of the 13 areas have reduced air pollution enough to meet federal standards.

Ecology's Hazardous Waste and Toxics Reduction Program has provided technical assistance to hundreds of hazardous waste-generating businesses, resulting in significant decreases in their use of hazardous substances and generation of hazardous wastes. Since July 1993, Ecology has conducted leak-detection compliance inspections of 1,325 underground storage tanks. Of these, 1,085 have been found to be in compliance. Ecology has conducted 473 informal and 47 formal enforcement actions at underground storage tank facilities. Since 1990, Ecology has received 1,571 reports of completed cleanups at sites with leaking underground storage tanks.

The Department of Agriculture's (WSDA) Waste Pesticide Collection Program is responsible for collecting and disposing of pesticides no longer used or those banned by the U.S. Environmental Protection Agency (EPA). The program focuses on waste prevention and is instrumental in preventing potential contamination of groundwater, surface water, and soil. Education and concerted efforts to contact pesticide users are important program elements. WSDA places a high priority on identifying chemicals found in unmarked containers because their unknown quality presents a special hazard in case of spills or inadvertent contact with humans or animals.

WSDA and the regional EPA office jointly staff the Integrated Pest Management in Schools Workgroup. The Office of the Superintendent of Public Instruction (OSPI), DOH, Ecology, Department of Natural Resources, local school district maintenance staff, and public advocates serve on the Workgroup which seeks to limit hazards associated with pest control in schools.

With funding from the Legislature through OSPI, DOH published a "School Indoor Air Quality Best Practices Manual" in February 1995. The Manual focuses on practices which can be undertaken during the siting, design, construction, or renovation of a school, as well as operations, maintenance, repairs, and school administrative organization. The purpose of the Manual is to promote practices which prevent or reduce indoor air contamination, thereby contributing to safe, healthy, productive, and comfortable environments for students, teachers, and other school staff.

As required under SSB5503, DOH published "A Preliminary Report: The Regulation of Temporary Worker Housing". In recognition of the size of the farmworker housing shortage, the report recommends a course of incremental progress that incorporates the twin goals of making it easier for growers to provide adequate and safe housing and making it more difficult for growers to operate unlawful and substandard housing. The final report will be submitted in December 1996.

The Food Safety Enhancement Advisory Group (FSEAC) completed its *Food Safety in Washington: Issues and Recommendations* report in September 1994, and has established priorities for future work. Comprised of representatives of WSDA, DOH, Washington State University, local health departments/districts, and the Legislature, FSEAC continues to meet twice yearly to advance its goal of identifying issues on food safety and strengthening the partnership between food regulating agencies and the food industry.

As required by legislation passed in the 1994 Session, L&I has undertaken several new initiatives related to chemically-related illness (CRI). Up to six CRI research projects are being funded in the 1995-97 biennium. In cooperation with DOH, a center for research and clinical assessment has been established at the University of Washington. A plan for making occupational diseases reportable conditions was developed with DOH and presented to the State Board of Health in May 1995. The plan recommends reporting of four occupational diseases: lead poisoning, dermatitis, hospitalized burns, and toxic hepatitis.

Reduce Tobacco Use and Exposure to Secondhand Smoke

As directed by the 1993 Health Services Act, the Department of Health (DOH) conducted a statewide campaign aimed at reducing teen risk behaviors. Specifically targeted were use of tobacco and alcohol. The Teen Risk Counter Advertising Campaign was conducted from July 1994-June 1995 and consisted of television and radio advertisements, as well as billboards and promotional events. Community partnerships with Project ASSIST (American Stop Smoking Intervention Study for Cancer Prevention) staff and youth tobacco prevention coordinators at local health departments/districts greatly enhanced DOH's efforts.

DOH has also implemented a "youth tobacco prevention program" in counties throughout the state. Created as a result of passage of ESHB2071 in 1994, the program mobilizes teens to become advocates for tobacco prevention and control activities, and distributes tobacco use prevention materials to local health departments/districts for dissemination to schools and youth groups. Adults in every county have been trained in tobacco use prevention issues and in mobilizing youth anti-tobacco use coalitions.

Since 1991, DOH has implemented Project ASSIST, a progressive public health approach to tobacco use prevention and control. Key constituents around the state are provided education and information to advocate for stricter tobacco control policies. ASSIST aims at reduction of: environmental tobacco smoke; tobacco advertising and promotion, especially to youth; financial incentives to sell or purchase tobacco products; youth access to tobacco products. Federal funding from the National Cancer Institute will end in 1998.

Reduce the Misuse of Alcohol and Other Drugs

The Legislature Acts

SSB5688 was passed to support the development of local screening programs for early identification of and intervention for fetal alcohol syndrome. DSHS, DOH, OSPI, and Department of Corrections are directed to ensure coordination of identification, prevention, and intervention programs for children with fetal alcohol exposure, and for women at high risk of having children with fetal alcohol exposure.

State Agencies Respond

Department of Social and Health Services (DSHS), Division of Alcohol and Substance Abuse (DASA) is currently embarked on several significant research/evaluation projects, including the following:

- Assessing the cost effectiveness of chemical dependency treatment for indigent adults, pregnant and parenting women, and assessing the cost effectiveness of collateral services such as vocational programs;
- Assessing the effectiveness of chemical dependency treatment provided to publicly-funded adolescent clients;
- Evaluating enhanced services provided to SSI recipients who are addicted to alcohol or other drugs;
- Evaluating opiate substitution services provided to opiate addicts;
- Developing reliable estimates of substance use, misuse/dependence, and demand for treatment in each county;
- Assessing rates of alcohol/drug use, misuse/dependence, risk, and demand for treatment among individuals in the criminal justice system;

- Estimating size of the population at risk for substance misuse based on prevalence of risk and protective factors;
- Assessing the co-morbidity of substance misuse with mental illness and other disabilities.

New and expanded DASA activities include:

- Increased coordination with the DSHS' Children's Administration and Juvenile Rehabilitation Administration to increase staff awareness of chemical dependency issues and availability of enhanced treatment services for chemically-dependent clients.
- Implementation with Community Public Health and Safety Networks, OSPI, DOH, and Department of Community, Trade & Economic Development of an assessment and planning model for drug and alcohol use prevention focusing on risk factor identification and enhancement of protective factors to reduce risk.
- Coordination with HCA, Medical Assistance Administration, counties, and providers regarding interface of alcohol and drug treatment services in the Basic Health Plan and Healthy Options programs.
- Provision of additional vocational and employment opportunities for clients recovering from chemical dependency using the Vocational Opportunities Training and Education (VOTE) program model and including two new sites in Yakima and Seattle.
- Provision of enhanced opportunities for Fetal Alcohol Syndrome screening through the establishment and training of six local diagnostic and screening clinics statewide.
- Expansion of treatment, referral, and monitoring services to individuals receiving Social Security Insurance benefits due to chemical dependency. In 1995, DASA received additional federal grant funds to significantly expand the population served through its nationally-recognized model.

In collaboration with the Department of Health and DASA, the Office of the Superintendent of Public Instruction completed the *Washington State Survey of Adolescent Health, 1994-1995.* The survey of public school students across Washington provides trend data on tobacco, alcohol, and other drug use, and data on student health knowledge and behaviors as well as risk and protective factors.

Reduce the Incidence of Violence and Preventable Injuries

The Legislature Acts

The Legislature passed SSB5141, the Omnibus Drunk Driving Act, focusing on three priority populations: underage drinking drivers, hardcore drinking drivers, and individuals needing treatment interventions. The blood alcohol content (BAC) required for citing persons under age 21 for DUI (driving under the influence) was lowered to .02. Penalties for drivers with BACs of .15 or more were increased. Deferred prosecution statutes were revised. Persons arrested for DUI twice within a five-year period are subject to having their vehicle seized.

STATE AGENCIES RESPOND

As required by the 1994 Youth Violence Reduction Act, the Department of Health (DOH) is organizing existing data on rates of various problem behaviors and presence or absence of risk and protective factors related to youth violence. These factors, which are reported for each Community Public Health and Safety Network, include rates of: poverty; single-parent families; youth homicide; youth suicide; accepted child abuse and neglect referrals; youth violent crime arrest; school dropouts; and births to young mothers.

As authorized by the 1994 Legislature, the Department of Labor & Industries is conducting two pilot studies in Everett and Yakima to test new methods of preventing long-term disability in Workers' Compensation. Outcome data will be collected through the 1997-99 biennium.

The Department of Social and Health Services (DSHS) initiated several health and safety initiatives to protect children in out-of-home care. Reviews were conducted of family foster homes, group care homes, therapeutic foster care and crisis residential care facilities. The 1995 Legislature passed SHB1906 enabling DSHS to take a more critical and proactive stance in licensing/relicensing facilities and responding to complaints and concerns.

DSHS is now managing an annual allotment of state funds specifically for the evaluation and treatment of sexually aggressive youth as part of the Community Protection Act.

DSHS is promoting initiatives to support and preserve families through:

- Advocacy for and involvement in the "Families for Kids" projects to reform permanency planning for children and families. Coordinated by Children's Home Society with grants from the Kellogg and Stuart Foundations, the project is managed by a coalition of state and private agencies, tribes, and other partners.
- Support for ESSB5885, passed in the 1995 Legislative Session, which strengthens family preservation efforts with Division of Children and Family Services' client families. Request for Proposals (RFPs) for Intensive Family Preservation Services have been released, designed to responsively address family and community needs.
- RFPs for Children Traditionally Served in Group Care will allow private agencies which have previously served children in residential facilities to wrap services around children in their own homes or in less restrictive foster care settings.
- Actively pursuing SSI eligibility for foster children in DSHS custody, evaluating and identifying treatment needs and creating a resource which will follow the child upon return home. Approximately 1/3 of children in out-of-home care qualify for this resource.

Assure Access to Population-Based and Personal Health Services, Including Health Education, Preventive Services, and Illness Care

The Legislature Acts

The Legislature passed three bills — ESSB5386, ESHB1046, and ESHB1589 — which modified the direction of health reform taken in the 1993 Washington Health Services Act. Basic Health Plan (BHP) subsidized enrollment will be expanded from 44,000 to 200,000 adults by July 1997. Subsidy levels are modified to increase enrollment. Employer share of BHP premiums for low-income employees was reduced. The BHP benefit package was enhanced to include mental health, chemical dependency, and organ transplant coverage. Up to 130,000 low-income children whose families earn between 100-200% of the federal poverty level will receive free medical and preventive dental care through Medicaid. Insurance brokers, hospitals, health carriers, rural health facilities, and community clinics will help residents apply for BHP and Medicaid.

Insurance reforms were preserved and strengthened. No one can be denied health insurance based on age, gender, medical history, or occupation. Residents cannot lose their insurance if they become ill. Insurers may impose no more than a three-month waiting period for pre-existing health conditions. Modified community rating must be used in setting small group and individual rates. Limits are placed on rate variation related to age of enrollee, and insurers may allow a discount of up to 20% for wellness activities. Employers are encouraged to offer health care savings accounts.

A nine-member Health Care Policy Board (HCPB) was established to replace the Health Services Commission, with a major focus on informing and involving the public. HCPB will periodically make recommendations to the Governor and Legislature and is assigned a list of required studies and projects. DOH and HCPB will study the feasibility of establishing a uniform quality-assurance program to be used by health care providers, insurers, and facilities, and will together continue to develop standards for collecting, storing, transmitting, and ensuring the confidentiality of health-related data.

Legislation was enacted to implement the Public Health Improvement Plan (PHIP). RCW 43.70.570 declares the Legislature's intent to implement PHIP recommendations by initiating a program to provide the public health system with the necessary capacity to improve health outcomes, and establishing a methodology by which improvement in these outcomes and delivery of public health services will be assessed. $9.75 million was allocated for the 1995-97 biennium for public health improvement, including $1 million for a statewide youth suicide prevention program.

The Legislature passed SSB5419 which prohibits issuers of health coverage from discriminating against Medicaid-eligible people at time of plan enrollment or payment of claims. The statute is expected to increase enrollment of Medicaid-eligible individuals in managed care plans.

In 1995, the Legislature passed E2SHB1908 which represents a major step in establishing a comprehensive range of long-term care services for seniors and people with disabilities. The law expands home and community-based residential options, increases provider reimbursement rates, and allows delegation of nursing tasks in

residential settings. The law also increases protection for vulnerable seniors, allows for estate recovery to recoup Department of Social and Health Services' long-term care costs, sets a new nursing home payment reimbursement structure, and provides for quality assurance in community settings.

The Legislature passed SSB5854 requiring health insurance carriers to allow female patients direct access, without necessity of prior referral, to timely and appropriate covered women's health care services provided by the enrollee's choice of type of providers. Providers may be women health care specialists or nurse-midwives. The Office of the Insurance Commissioner adopted rules to implement the law, including prohibitions against insurance carriers establishing different costs or special fees which might discourage women from seeking women's health care services.

State Agencies Respond

As required under ESHB1589, in December 1995 the Department of Health published a preliminary report on quality assurance and health care data standards. The report outlines areas in which public/private partnerships have been established to provide needed data on chronic diseases. The report contains recommendations regarding the feasibility of a uniform quality assurance and improvement program.

The Health Care Authority (HCA) is dedicating significant new resources to the Basic Health Plan (BHP) to improve operations, marketing, affordability, and benefit design, thus increasing ability to accelerate enrollment growth. Efforts are underway to make BHP accessible through a variety of avenues in communities across the state. Cooperation of insurance brokers, hospitals, community clinics, and insurance carriers is being enlisted in helping residents apply for BHP.

The Department of Social and Health Services (DSHS), Medical Assistance Administration (MAA) has implemented a number of cost containment efforts that address the need to balance increasing costs with escalating demand for services. These include: developing and implementing managed care delivery models; developing utilization management and quality assurance standards; changes in contracting, fee schedules, and reimbursement; placing limitations on services; coordinating third party benefits to ensure MAA is payer of last resort; and expanding medical services for children in special education through efforts to access federal funds.

In September 1995, MAA initiated the expansion of the Healthy Options program to certain SSI clients who are not in institutions or who have joint Medicare/Medicaid coverage. Healthy Options' plans and other providers in Clark County will be the first to begin mandatory enrollment for these clients with a Primary Care Case Manager. MAA envisions Healthy Options - SSI will evolve into a fully-capitated, risk-based delivery model. MAA plans to expand the program by the end of 1997.

DSHS, Division of Children and Family Services (DCFS) (with other DSHS divisions and community agencies) is promoting collaborative efforts to improve preventive health care for children by educating and encouraging parents, foster parents, service providers, and social work staff regarding the Healthy Kids/EPSDT well-child health screening program. Work is underway to create and implement a "health passport" system to collect and track health history and treatment information for DCFS-client children.

In 1994, the Office of the Insurance Commissioner (OIC) implemented regulations eliminating health screening of insurance applicants, and guaranteeing portability and renewability of coverage. These reforms were enacted in statute by the Legislature as part of 1995 health reform legislation.

During 1994-95, OIC moved to regulate three key areas of concern for seriously ill individuals. Regulations no longer allow insurance companies to reject coverage of federal Food and Drug Administration-approved drugs for medically-appropriate uses other than those for which the drugs were initially approved. Other rule changes require insurers to apply hospitalization coverage to alternative forms of care — home, hospice, or other situations which patient and health care provider feel are more appropriate. Rules were adopted to allow life insurance companies to add "accelerated benefits" clauses to contracts so that terminally-ill patients might have an option of receiving policy benefits before death.

OIC has also adopted regulatory standards for the viatical industry — in which investors broker the sale of terminally-ill individuals' life insurance benefits. Agents and companies must be licensed, and brokers registered with OIC, and meet solvency and market-conduct requirements. OIC also will monitor market activity to ensure insurers provide access to all types of health care providers who furnish health care services listed as benefits in the Basic Health Plan. OIC continues efforts with other state agencies and the private sector to find ways for state residents to meet their long-term care needs without falling into poverty.

As authorized by legislation enacted in 1993, the Department of Labor & Industries is conducting a Managed Care Pilot Study for injured workers. More than 21,000 workers are enrolled in the study to determine cost, outcome, and worker satisfaction with managed care in the treatment of injuries. The study will be completed in January 1996.

PACIFIC COUNTY

Martha Murfin

THROUGH MARTHA'S EFFORTS, YOUNG MOTHERS ON THE LONG BEACH PENINSULA NOW ATTEND HIGH SCHOOL.

At Ilwaco High School, eight teen mothers attend classes every day thanks to a 77-year-old woman who, in her own words, just will not quit talking. Says Martha Murfin, "I've found that if you just keep talking about a problem, more often than not it gets addressed. I'm not the kind who gets discouraged. I'm told I'm very persistent."

Through Martha's efforts, young mothers on the Long Beach Peninsula now attend high school, thanks to infant care provided through Kids In The Educational System (KITES). Before KITES, girls with newborn infants could not attend high school because they had no place to leave their babies. Now, the infants receive quality care at an in-school daycare center.

But Martha's dedication to helping the people of the Long Beach Peninsula reaches far beyond the high school. Through involvement in several different local organizations, Martha sometimes gets 15 telephone calls a day, almost all of them about families facing some emergency.

"Yesterday a young mother left her infant with a 15-year-old babysitter and never came back," she says. "We needed diapers, formula, everything. Child Protective Services was called. We're also working with the distraught mother."

Much of her work involves connecting families with basic necessities. For example, Pacific County's Food Bank opens only two days a month. The rest of the time hungry families rely on volunteers like Martha. "After church I got three calls," she relates. "I took each one of them a box of food."

Martha's main interest is helping children, especially infants. "It's a shame," she says. "These kids are born into these messes and never get out. I've found, though, that if you just look hard enough, there's a way you can help these children."

After 25 years of helping people in Pacific County, her stories are endless. Sometimes a problem that would be a minor situation for most parents seems insurmountable for the disadvantaged. When the weather turns cold, adequate clothing is a priority. She maintains, "No child in our area should have to be without decent clothing. With a little bit of love and caring, they don't have to. A teacher called me the other day, and I took over five coats for one family. Somehow it always seems to work out."

Kathy Spoor, R.N., Pacific County Health Department Director, considers Martha a tremendous asset to the entire area. "Martha genuinely cares about people," Spoor says. "She is amazingly ingenious at finding resources, and she never asks unless it's absolutely necessary. She is sensitive to cultural situations. I remember an Hispanic family needing rice, unavailable from the local food bank. Martha walked in with this 30-pound bag. She could barely carry it. I still don't know where she got it from."

Although Martha has a "little bank account," most of her work involves connecting people in need with the best resource, either public or private. She says, "None of what I've done was only a 'Martha Project.' Peninsula people have been extremely generous with money, food, clothing, and support."

Often the family problems involve alcohol or other drugs. In some cases, she asserts, "people with infants never learned to cope so they just quit trying."

One way or the other, Martha plans to keep on helping the people of Chinook, Seaview, Ilwaco, Long Beach, Oysterville, and all the other little towns in the area. "People say nice things about me, but I'm not someone who needs touting a whole bunch. I just keep on pedaling."

King County

Sam Chung

Our goal is to provide people who can listen. After that, what we have to offer is good traditional medicine.

Preventing disease can be a challenge among Washington's 70,000 member Korean-American community where English often is a second language.

"Communication is half the battle," explains Sam Chung, a Seattle-based attorney and President of the Board of Directors, Korean Community Counseling Center. "Most people don't realize what a difficult place this is if you don't speak the language. The problems are unimaginable." He says low-income Korean-Americans may end up visiting doctors who do not understand a word they say. Often immunization does not occur, leaving the community open to a variety of diseases.

About 40 low-income Korean-Americans in Federal Way received help in October 1995 at a special medical clinic sponsored by the Korean Community Counseling Center, Korean Women's Association, and Federal Way Korean Christian Counseling Service. First stop for many, especially children, was the immunization table. There they received vaccinations against diphtheria/pertussis/tetanus (DPT), measles/mumps/rubella (MMR), and haemophilus influenza Type b (Hib), which most other American children receive before age 2. Seniors also received immunization against pneumonia.

Sam came up with the idea for a clinic after his mother became ill and had difficulty explaining her condition to English-speaking health care providers. Sam knows what it is like not to speak the language. He came to the United States at age 12. "All I knew were the capital letters of the alphabet," he says. Sam worked closely with Dr. Jay Kim, Korean Women's Association President, and Oksoon Park, Federal Way Christian Counseling Service Executive Director, and solicited help from a number of people in and out of the Korean community for more than a year before the clinic finally came together.

"We are targeting low-income individuals and seniors," Chung emphasizes. "Often these people don't have money for necessities, so they generally hesitate to seek medical care unless something is wrong. Our goal is to provide people who can listen. After that, what we have to offer is good traditional medicine."

Along with specialists in obstetrics, gynecology, pediatrics, and internal medicine, the clinic offered dental services, and acupuncture. Providing assistance with the clinic were the Korean-American Physicians Association under the leadership of its President Dr. Jonathan Jin, two volunteer nurses, and the Seattle-King County Department of Public Health. "Physicians were pleased to be able to donate their time to improve the health of our community," says Dr. Jin. Food, clothing, and other basic necessities were made available through the WIC (Women, Infants and Children) program.

The clinic was such a success that another one is scheduled for January 1996 in Tacoma and another later in North Seattle. It has also sparked new cooperative health endeavors. The Korean-American Physicians Association and the Korean Women's Association in 1995 co-sponsored the first "Health Seminar for the Korean Community", stressing health promotion and disease prevention. More than 200 Korean-Americans attended what is hoped will become a continuing series.

CLALLAM COUNTY

Gary Smith Family

GARY SMITH'S STEWARDSHIP SETS AN EXAMPLE FOR THE ENTIRE COMMUNITY.

When fecal contamination threatened the shellfish of Sequim Bay, Gary Smith and his family became part of the solution.

To start, the Smiths invested $60,000 in enhancing water quality of the creek that passes through the 1,000-acre farm which has been in the family for three generations. Their Maple View Farm is located where Bell Creek pours into Sequim Bay. The Smiths improved waste management, controlled runoff, recycled wastewater, and eliminated livestock access to Bell Creek and irrigation ditches. They worked closely with Clallam Conservation District and Soil Conservation Service to develop a farm conservation plan. As a member of the Sequim Bay and Dungeness Watershed Management Committee, Gary helped to develop a plan to prevent and correct nonpoint sources of pollution in the watershed.

Shannon Smith, Gary's daughter-in-law, as leader of the local 4-H group, encourages 27 local young people to understand and participate in the lifestyle of the family farm. Along with traditional activities, Shannon's 4-H group created a large diorama of a model farm, which demonstrated Best Management Practices used to protect resources, much like the ones used on the real Maple View Farm. Shannon also makes presentations to groups around the county and state on farm stewardship. Thanks to her enthusiasm, her 4-H group is now looking for new projects to promote environmental awareness in the agricultural community.

The Smiths' enthusiasm is contagious. Sequim schools rear salmon fry in their classrooms and reintroduce them into Bell Creek. They also plant streamside vegetation and engage in clean up activities. Other landowners, developers, the Jamestown S'Klallam Tribe and the City of Sequim have rehabilitated portions of Bell Creek, as well. The Clallam Conservation District and Washington Department of Fish and Wildlife help coordinate activities and provide technical assistance.

After six years of collecting water quality data, Clallam County Department of Community Development, Environmental Health Division, found a marked decrease in fecal coliform bacteria at the mouth of Sequim Bay, much of it attributable to improvements at Bell Creek. Eric Crecelius, Battelle/Marine Sciences Laboratory Senior Research Scientist, says, "Gary Smith's sense of personal responsibility and stewardship sets an example for the entire community."

Although Sequim Bay's cleanup program still has goals to reach, one sign of success did not have to be seen in a test tube. Salmon have returned to spawn in Bell Creek after a long absence. Says 1995 Clallam County Board of Health Chair Dave Cameron, "This has been a concerted effort on the part of the County, agencies, and citizens of Sequim Bay watershed. It's an excellent example of the way watershed planning is supposed to work."

SPOKANE COUNTY

Dr. Dennis Biggs, Jr.

HIS FIRST GOAL WAS TO PREVENT CHILDREN FROM BUYING CIGARETTES.

Smoking kills. In Washington State 8,000 people die each year as a result of tobacco use. But Spokane physician Dr. Dennis Biggs, Jr. did not die from his long-time addiction to cigarettes. However, smoking killed his wife.

"Having been a smoker for many years and having introduced my wife to smoking, I had a strong sense of guilt over her illness and death," he says regarding his wife's death from emphysema. Dennis decided to turn his grief into a commitment to stop smoking in Washington State. He joined the local tobacco control coalition, when his wife first became ill. He now belongs to the state and county chapters of Tobacco Free Washington and is a board member of the Spokane unit of the American Cancer Society.

His first goal was to prevent children from buying cigarettes. He discovered that although a state statute forbade selling or giving tobacco products to children, the law had no enforcement provisions. He successfully worked for a Spokane County Health District Board of Health regulation providing for enforcement. Even so, some local stores still openly sold cigarettes to children. A letter asking stores to stop the practice produced poor results. Dennis recruited his then 14-year-old granddaughter Jessie to participate in sting operations. Despite a newspaper article warning of the stings, about half of the stores in town would sell her cigarettes. But the stings have been effective and continue. Today only 22% of Spokane stores still sell cigarettes to minors.

Although Spokane and a few other counties around the state enforced the statute, many did not. Dennis was instrumental in the development of a 1993 statute that put the Liquor Control Board in charge of statewide enforcement. He also lobbied at his own expense for Tobacco Free Washington during the 1994 Legislative Session.

He targeted a local issue once again when he noticed tobacco companies passing out samples of chewing tobacco on the Spokane County Fairgrounds. According to Dennis, the Spokane County Fairgrounds was the site of the largest distribution of tobacco samples in the state. At the urging of Tobacco Free Washington, the Spokane County Board of Commissioners took action to inform tobacco companies that tobacco sampling on county property is illegal. The sampling has now stopped.

Dennis also has been working to make smoking illegal in all restaurants in Spokane County. After unanimous agreement by the Health District Board of Health, various routes are being explored to ban restaurant smoking.

Today, Jessie Biggs also remains active in the fight against smoking and is a member of STAT (Spokane Teens Against Tobacco). She teaches other youth about the dangers of tobacco use, and continues to participate in sting operations for the Liquor Control Board in its enforcement of laws prohibiting children from obtaining tobacco. She took part in a youth rally against tobacco held in Olympia during the 1995 Legislative Session and attended a national conference against tobacco in California that summer.

Both Biggs plan to continue their fight against this dangerous, addictive killer in Washington State. As Elaine Blair, Spokane County Health District Director of Health Education/Health Promotion, says, "They're a breath of fresh air in a smoky room."

PIERCE COUNTY

Maurice Martin

MAURICE TOOK RESPONSIBILITY FOR HIS ADDICTION AND FOUND HELP.

After 20 years of heroin addiction, in 1987 Maurice Martin received what he calls a message from God — he almost died from an overdose .

"I took a big ball of black tar heroin and half a spoon of coke," he says. "They call it a speedball. The medics told me if they had gotten there four minutes later, I'd be a corpse." The experience finally convinced him he needed help. After a term at the Monroe Reformatory and a history of crime, it would be a long road back.

Maurice took responsibility for his addiction and found help through a program funded by the Alcohol & Drug Addiction Treatment Support Act (ADATSA). ADATSA has three goals: prevent welfare caseload growth; stop the diversion of state funds in welfare checks for purchases of alcohol and drugs; and reclaim Washington's addicted client population.

"It's like a rebirth," he says of his life without drugs. "It feels good to be an honest person."

Living in a Tacoma recovery house, Maurice took his first step toward employment with the Vocational Opportunity Training Education (VOTE) program at Pierce College. VOTE helps people coming out of treatment learn how to get a job. VOTE participants earn 10 college credits for completing the course. Participants assess their skills and interests, study the job market, and develop job search skills. While the short-term goal is employment, students also make plans for meaningful careers. "I didn't even know what a cover letter was," Maurice remembers. "It was like learning a foreign language."

Through VOTE, Maurice got a job at a mattress factory. It took care of immediate financial needs, but he wanted to do better. After earning an Associate Degree in Business Administration, he went to work at Nordstrom's, where he has earned success as a top salesman in the women's shoe department.

"He's a joy to work with, a great guy," says Peter Nordstrom, Store Manager. "He always has a smile and a can-do attitude. The guy is like one of our family here, and we get letters about him all the time. He's a real contributor to society." Maurice gives back to his community, both by teaching aerobics at the local YMCA, and as baseball coach at Hunt Middle School in Tacoma.

The taste of success is spurring Maurice on toward what he calls "a higher plateau." He plans to earn a Bachelor's Degree in the near future and from there move on to new goals.

KITSAP COUNTY

Jeffrey J. Pritchard

OUR OBJECTIVE IS FOR EVERY CHILD TO HAVE ACCESS TO A HELMET.

Jeffrey Pritchard woke up when they started sliding a tube down his throat. He had been hit and dragged by a car one night while riding his bicycle on Bainbridge Island and lay on a rain-soaked street, medics working to keep him alive.

Lying there in the dark made him realize how vulnerable he was. "It's not much of a contest between you and a truck or car," Jeffrey says. Later, after being airlifted to a hospital, doctors found he had seven broken ribs, a crushed lung, and lacerated liver. They also found his brain undamaged thanks to the helmet he had been wearing.

That made Jeffrey wake up to something else — that everyone (particularly children) should wear a helmet while riding a bicycle. At the Bremerton-Kitsap County Health District, he learned that many children did not wear helmets, and others in the community were concerned about it too.

Across the nation the statistics are grim:

- Nearly one million children under age 14 are treated each year for bicycle injuries.
- 50% of those killed in bicycle-related deaths are children.
- 70% of those treated in emergency rooms for bicycle-related injuries are children.
- More than 260,000 children hospitalized with bicycle injuries suffer head trauma.

In his job at U.S. Bank, Jeffrey works with nonprofit groups and foundations and used his expertise to set up the "Helmets for Youth Foundation" a year after his life-threatening injury. "Helmets for Youth" makes bicycle helmets available at no cost to children from low-income families. The Foundation raised more than $15,000 and handed out helmets through the Bremerton-Kitsap County Health District. The Foundation also has worked with the Regional Emergency Medical Services, Tacoma Care Council, and local schools to distribute helmets. The target is children ages 3-15. "Our objective is for every child to have access to a helmet," Jeffrey says. The Foundation pays $12-$18 for helmets that would retail for $35-$60.

Just passing out the helmets is not enough. "It is important," Jeffrey says, "to make sure the helmet fits right." Along with the helmets, kids get educational materials that explain how to fit and wear them.

Jeffrey wants to spend up to 1/3 of the Foundation's money each year, leaving the rest in the bank to earn enough to keep the program going year-after-year. "I didn't want this to be a one-shot deal," he says. "It has to be ongoing so every year, new children can get helmets." Jeffrey emphasizes that 100% of each contribution goes to buy helmets.

By early 1995, Jeffrey's Foundation had distributed more than 2,000 helmets to young Kitsap County bicycle riders. For his efforts to get children to wear helmets, Jeffrey was named the 1994 Kitsap County Public Health Volunteer of the Year.

YAKIMA COUNTY

Gloria Mendoza

HER SUPPORT BEGINS WITH A SMILE AND SOMETIMES A FEW WORDS SPOKEN IN SPANISH.

The economic vitality of Washington's $5 billion agricultural industry depends on farmworkers. Providing health care access to these low-income workers and their families is a challenge. But when health care access, especially to preventive services, for any group of Washington residents is expanded, we all benefit—through increased productivity, reduced disease transmission, and better overall control of health care costs.

Gloria Mendoza, a volunteer health worker in Yakima. is doing what she can to help. Her support begins with a smile and sometimes a few words spoken in Spanish. "I'm a people person," she says. "I enjoy being around people from all walks of life."

According to Pat Brown, Department of Social and Health Services' (DSHS) Program Manager for "Healthy Kids", "Volunteers like Gloria are the difference between success and failure for a number of local health care access programs." The need is staggering. In Yakima County alone 55% of children are eligible for Medicaid. Once, farmworkers and their families came and went with the seasons, but today many are year-round Washington residents and taxpayers. Says Pat, "This agency has been very reliant on volunteers, particularly at the point of contact. Volunteers are effective because clients aren't afraid to walk up to them and talk about their needs."

At the Smile Saver Dental Clinic, where she volunteers regularly, Gloria says the kids are especially scared. She adds, "I try to get them to relax. We pass out a lot of fluoride pills, which we hope will result in there being fewer problems in the future." The Clinic operates at different sites around the county, offering a wide range of dental services to low-income residents. Yakima County has only 77 dentists for its 185,000 residents, so low-income individuals may have a difficult time finding a dentist.

Gloria also works on the "Smile Mobile", a brightly painted van that brings dental care to the schools. This is a collaborative project of the Washington Dental Services Foundation and Washington State Dental Association. The van, like the Smile Saver Clinic, offers everything from checkups to fillings.

At the immunization clinic set up in the downtown Yakima DSHS building, Gloria helps people sign in and generally keeps the clinic rolling. The clinic got its start when Pat Brown noticed the old "smoking room" was no longer in use. It was a perfect location, near state offices that offer assistance to low-income residents. The clinic in the DSHS building is one of five now operating in the County.

One stumbling block to health care for people with low incomes is enrolling them in Medicaid. Many Yakima County residents are not aware they are eligible for Medicaid even if they earn up to 200% of the federal poverty level. To get the word out, Pat and Gloria staffed a booth at Safety Saturday, a carnival-like event held in a parking lot, that teaches children about home safety. "We set up a safety maze," Pat says. "Before the kids started, we would hand the parents a sheet explaining Medicaid eligibility, and the fact that people don't have to come down to our office to sign up. They can do it all through the mail."

For needs not met through DSHS programs, Gloria and agency employees recently sold cookies and coffee at a highway reststop to raise money for a special "Christmas Through the Year" Fund.

Stella Vasquez, Region 2 Administrator, DSHS Community Services Division, says Gloria's work has not been just helpful. "Without that additional volunteer pitching in, our whole effort fails," she says. "We've got to have her. We're all very grateful."

High Priority Health Study Issues

In accordance with RCW 43.20.050 and 43.70.050, the State Board of Health consulted with state agencies for a list of recommended high priority health study issues related to the Washington State Priority Health Goals for the 1997-99 biennium. This list has been reviewed by the Board. Included is a brief objective of each study, with a suggested timeframe, and estimated cost.

Department of Agriculture

Identification of On-Farm Reservoirs for *E. Coli* 0157:H7 and the Characterization of These Strains Versus Resident Strains:

Principal investigators are the U.S. Department of Agriculture Animal and Plant Inspection Service Veterinary Services and Washington State University, with assistance from Washington State Department of Agriculture. Twelve cattle herds — four each from Washington, Idaho, and Oregon — will be selected for sampling. Sampling will include fecal samples from cattle as well as local deer, elk, rodents, cats, birds, and insects in vicinity of cattle operations and feed and water suppliers. Non-bovine species may represent a vector and/or reservoir for *E. coli* 0157:H7. Detection of any non-bovine farm reservoir would be crucial in determining how the organism persists on-farm. Timeframe: 2 months. Cost: $20,000.

Department of Ecology

Health Effects of Living Near Hazardous Waste Facilities:

To assess health effects on citizens based on proximity to facilities that generate or handle hazardous wastes. The proximity of residential housing to facilities, both public and private, that deal in any way with materials which are a public nuisance or potentially dangerous continues to be a public concern. Recently, the concept of "environmental equity" has received a fair amount of attention at both the national and state level. Environmental equity can be described as the proportionate and equitable distribution of environmental benefits and risks among diverse economic and cultural communities. Assessment of health effects of living near hazardous waste facilities is necessary before it can be determined if a disproportionate share of risks are borne by low-income or minority communities. Timeframe: 6 months. Cost: Undetermined.

Protocols Necessary for Monitoring Toxic Blooms of the Blue-Green Algae "Anabena":

To develop risk assessment protocols including test procedures, action thresholds, and lab certification requirements to ensure adequate public protection. "Anabena" is common in freshwater lakes and is frequently associated with nutrient enrichment. It can release toxins into the water column that, at high concentrations, are toxic to mammals. Timeframe: 6 months. Cost: $100,000.

Evaluation of Alternative Bacterial Indicators as Proposed by the U.S. Environmental Protection Agency:

The EPA proposed that states use enterococcus, a different bacterium than standard coliform bacterial indicators, to more accurately identify harmful bacteria in

bodies of water. This study is intended to analyze the relative correlation between indicators and occurrence of illness in humans to determine whether enterococcus is a better indicator. Timeframe: 24 months. Cost: $150,000.

Assessment of Nitrate Levels and Related Health Effects:

A multi-year, multi-agency effort, including Ecology and DOH, to study health effects of elevated nitrate levels found in groundwater in Grant, Adams, Lincoln, Franklin, Benton, and Whitman Counties. Nitrates can pose long-term health problems and, in the case of infants fed with formula made with high-nitrate water, can cause acute effects. At end of this phase of study, local governments and state agencies will work together to determine appropriate solutions.
Timeframe: Undetermined. Cost: Undetermined.

Department of Health

Public Health Improvement Plan (PHIP) and State Health Assessment (SHA):

Major DOH efforts are focused on the second phase of PHIP and preparation of SHA. Current efforts are directed at implementing 1994 PHIP recommendations and continued PHIP development. DOH and local health jurisdictions are aiming at achievement of PHIP capacity and outcome standards. Ongoing PHIP development includes: identification of performance measures of core public health functions; analysis and recommendations for stable public health financing at state and local levels; and identification of criteria to encourage partnerships across communities to achieve capacity standards. Timeframe: Ongoing through 1999. Cost: Undetermined.

SHA will be an ongoing objective appraisal of the health of Washington residents and capacity of state's public health and health care systems to promote and protect residents' health. Information contained will provide a foundation for development of the next biennial PHIP, and contain information for use by the legislature, DOH staff, State Board of Health, other state agencies, local health jurisdictions, Community Public Health and Safety Networks, and other community-based organizations. SHA will serve as an empirical basis for policy decisionmaking, prioritization of efforts, program management, budget development, and resource allocation. Timeframe: Ongoing, with periodic updates.
Cost: Undetermined.

Assessment of Access Barriers:

Recognizing communities may use different assessment models, to study the results of community assessment to assure access barrier data are included, gather additional information, and complete analysis. Timeframe: 1997-99 biennium. Cost: $50,000.

Health Effects Studies Related to Air Pollution:

As the lead health agency, DOH is providing information, toxicology and epidemiology consultation, evaluation, and assistance to Ecology for various studies designed to assess health effects and health costs of air pollution to aid in risk management decisions and implementation of appropriate control strategies. Timeframe: 6 months - 1 year. Cost: Undetermined.

Impact of Compost Facilities on Health of Communities:

To study the prevalence of health symptoms among residents in communities adjacent to two compost facilities in Spokane County. Timeframe: 12 months. Cost: Undetermined.

HUMAN HEALTH ADVISORY PROTOCOL:

To develop health assessment protocols to include scientific and policy analysis for the development and communication of health advisories. Timeframe: 12 months. Cost: Undetermined.

HAZARDOUS SUBSTANCE EMERGENCY EVENT SURVEILLANCE SYSTEM:

An ongoing multi-year surveillance project to describe prevalence and distribution of hazardous substances events, identify risk factors, and develop strategies to reduce associated morbidity and mortality. Timeframe: Ongoing. Cost: $85,000/year.

HEALTH CARE AUTHORITY

BASIC HEALTH PLAN (BHP) AFFORDABILITY AND ACCESSIBILITY:

To study BHP affordability and accessibility to low-income residents, including the effects of recent changes in BHP subsidies. The BHP is the main vehicle designed and offered by the state through which low-income working adults have access to health insurance. It is important to ensure that cost is not a barrier to those people the program was designed to serve. Timeframe: Ongoing. Cost: Undetermined.

EMPLOYER GROUPS AND BHP:

To study the marketing of BHP to employer groups to ensure the product is responsive to their needs. This is important because a significant portion of Washington's population works for small employers. The BHP needs to ensure that employers know about the program, and that it complements their efforts to provide health insurance to their employees. This will provide another avenue through which many more residents will have access to affordable insurance. Timeframe: Ongoing. Cost: Undetermined.

RISK ADJUSTMENT:

To develop risk assessment models and a practical risk adjustment mechanism. Study to be undertaken with the University of Washington and funded by the Robert Wood Johnson Foundation. As the trend toward managed care and capitated payment systems continues, risk adjustment is one of the most important reimbursement issues on the horizon. Payments to managed care organizations must be distributed in a way that does not penalize plans that enroll and treat predictably higher risk populations. Timeframe: mid-1997-99 biennium. Cost: $1 million.

INFORMED CONSUMER DECISIONMAKING:

To assess how best to use data on cost, quality, and satisfaction to assist consumers in making informed choices when selecting health plans. More and more payers are asking consumers to contribute to the cost of their health insurance premiums, which often vary based on choice of health plan. Because the Health Care Authority is asking plan members to make decisions that can affect their income as well as their health care, quality and availability of information on which to base these choices is critical. Timeframe: Ongoing. Cost: Undetermined.

DEPARTMENT OF LABOR & INDUSTRIES

LONG-TERM DISABILITY PREVENTION PILOT:

To conduct two pilot projects in Yakima and Everett on community-based interventions aimed at preventing disability among injured workers. Timeframe: End of 1997-99 biennium. Cost: $2 million.

CHEMICALLY-RELATED ILLNESS:

Up to 10 research projects to conduct research on chemically-related illness relevant to the health of Washington residents. Timeframe: End of 1997-99 biennium. Cost: Undetermined; $1.3 million allocated in 1995-97 biennium.

MEDICAL OUTCOMES:

To study ongoing outcomes of key medical and surgical problems related to the care of injured workers. Timeframe: End of 1997-99 biennium. Cost: $750,000.

OFFICE OF THE SUPERINTENDENT OF PUBLIC INSTRUCTION

SURVEY OF ADOLESCENT HEALTH BEHAVIORS:

To identify youth populations in need of services and develop strategies to address problems. Undertaken in coordination with Department of Health and Department of Social and Health Services, Division of Alcohol and Substance Abuse. Timeframe: 1998. Cost: Undetermined; 1996 Survey is expected to cost $170,000.

STUDENT HEALTH CARE NEEDS:

To survey available health data related to children in school, consolidate and analyze for service implications, and determine need for additional data. The last survey of student health care needs was reported in 1989. Timeframe: 1 year. Cost: $60,000.

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

EXTERNAL ANNUAL QUALITY OF CARE REVIEW:

To study, in collaboration with the Oregon Medical-Professional Review Organization (OMPRO), whether Medical Assistance Administration managed care plans' quality of care meets certain state and federal criteria and/or accepted practice guidelines. External review of care is currently a federal requirement. OMPRO provides a detailed evaluation of client record-level data for each plan. These data are important for plans' quality improvement processes and state monitoring and oversight. Sampling methodology has been refined over the external review contracting period to reflect more representative performance. Included in the evaluation are prenatal care, child immunization, EPSDT, and other services. As SSI clients are added to managed care, study components will be expanded to include care and coordination of services for the disabled population. Timeframe: 1997-99 biennium. Cost: Undetermined; Cost for 1995-97 biennium is $900,000.

NURSING FACILITY CASE MIX PAYMENT:

Pursuant to a 1994 legislative mandate, Aging and Adult Services is undertaking a study of alternative nursing facility payment methodologies. The goal is to adopt a new system based on the assessed care needs of residents, while providing incentives for cost effectiveness. The study process includes consultation with consumers, providers, and related programs in other states. Timeframe: legislative reports due in October 1995, 1996, and 1997, with completed study due January 1998. Cost: $400,000.

POPULATION-BASED MENTAL HEALTH SERVICES:

In collaboration with the National Center for Mental Health and DSHS Mental Health Division, a U.S. Public Health Service study to identify client service and demographic data as well as expenditure information on population-based mental health services. A pilot is underway; future study is dependent on pilot study results and federal funding. Timeframe: 1997-99 biennium. Cost: Fully federally funded.

Morbidity and Mortality in Severely Mentally Ill Individuals:

DSHS Mental Health Division is assisting in a Harvard University study to identify causes of excess morbidity and mortality in severely mentally ill individuals. Timeframe: 1997-99 biennium. Cost: Fully funded by National Institute of Mental Health through Harvard University.

Evaluation of Opiate Substitution Services Provided to Opiate Addicts:

To assess treatment outcomes of clients receiving opiate substitution services including changes in the use of drugs, involvement with the criminal justice system, employment, use of emergency rooms, as well as use of inpatient medical and psychiatric services. This evaluation is designed to help determine program effectiveness for different types of patients, to assess reductions in harm to both the patient and the community, as well as monitor and improve program performance on an ongoing basis. Information gleaned from this evaluation will be used in planning, as a basis for making resource allocations, and in policy development. Timeframe: January 1998 completion.
Cost: Undetermined.

Cost-Benefit Assessment of ADATSA Treatment:

To perform a "cost-benefit" or "return-on-investment" analysis associated with ADATSA treatment based on employment, Medicaid savings, treatment re-entry costs, income assistance, and (data permitting) incarceration costs. The benefits of treatment will be compared with the known costs of treatment in order to yield useful information to estimate the magnitude and types of net benefits or net savings due to treatment. One use of the results following from this analysis will be to inform decisionmakers on how cuts in funding of treatment services may raise expenses in other programs. Timeframe: September 1997 completion.
Cost: $20,000.

Cost Effectiveness of Prenatal Substance Abuse Programs:

In collaboration with the Center for Health Economics Research (Waltham, Massachusetts), to quantify public cost-savings associated with alternative prenatal treatment modalities and identify which services are cost-effective at producing the desired outcomes. This study takes a comprehensive view of the types of costs that may be incurred (or saved), extending beyond health care expenditures to also include public outlays for income and food assistance, as well as for child protective services. In considering the cost effectiveness of alternative treatments, public policymakers will have the opportunity to consider costs (and savings) not only to the health care system, but to society-at-large. Timeframe: September 1997 completion. Cost: Undetermined; funded by the National Institute on Drug Abuse.

Ongoing Evaluation of Publicly-Funded Chemical Dependency Treatment Services:

To evaluate publicly-funded chemical dependency services by assessing outcomes of a representative sample of patients at discharge and six months after discharge in a number of areas including alcohol/drug use, employment, criminal justice involvement, emergency room use, as well as use of inpatient medical and psychiatric services. This ongoing evaluation is designed to help determine efficacy of treatment for different types of patients as well as to improve program performance. Information from the evaluation will be used in planning, as a basis for making resource allocations, and in policy development. Timeframe: Ongoing.
Cost: Undetermined.

Appendices

Leading Causes of Death in Washington State – 1994

Percent of 39,829 Total Deaths

- Heart Disease 28.0%
- Cancer 24.6%
- Cerebrovascular Disease 7.9%
- Chronic Obstructive Pulmonary Disease 5.7%
- Unintentional injury 4.3%
- Flu/Pneumonia 3.7%
- Diabetes 2.6%
- Suicide 1.9%
- AIDS 1.5%
- Arterial Disease 1.3%
  (Diseases of the arteries, except arteriosclerosis)
- Other 18.5%

Source: Center for Health Statistics, Washington State Department of Health

The mission of public health is to assure conditions in which people can be healthy. Public health carries out this mission by collecting and analyzing information pertaining to various illness conditions, and implementing and evaluating strategic approaches to prevention, promotion, and intervention. The tables on this page indicate that while mortality data reveal disease or injury conditions as causes of death, actual causes of death can be addressed by public health approaches.

Leading Causes of Death in the U.S. – 1990

Total Deaths, U.S. - 1990 = 2,148,463

- Heart Disease 720,058
- Cancer 503,322
- Cerebrovascular Disease 144,088
- Unintentional injury 91,983
- Chronic Lung Disease 86,679
- Pneumonia & Influenza 79,513
- Suicide 30,906
- Chronic Liver Disease/Cirrhosis 25,815
- HIV Infection 25,188

Source: National Center for Health Statistics, *Advance Report on Final Mortality Statistics, 1990*

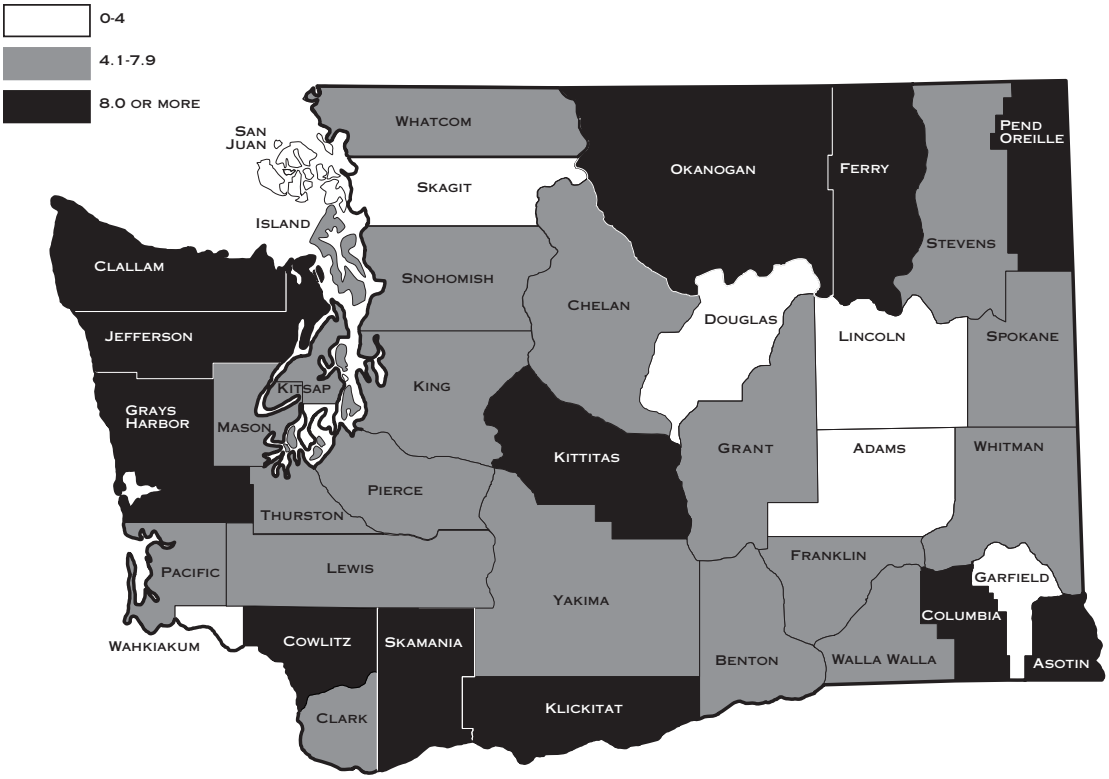
Leading *Actual* Causes of Death in the U.S. – 1990

- Tobacco 400,000
- Diet/Activity Patterns 300,000
- Alcohol 100,000
- Microbial Agents 90,000
- Toxic Agents 60,000
- Firearms 35,000
- Sexual Behavior 30,000
- Motor Vehicles 25,000
- Illicit Use of Drugs 20,000

Source: McGinnis, J. Michael and William H. Foege, "Actual Causes of Death in the United States", *Journal of the American Medical Association,* Volume 270 No. 18, November 10, 1993, 2208

Infant Mortality Rate Washington State – 1994

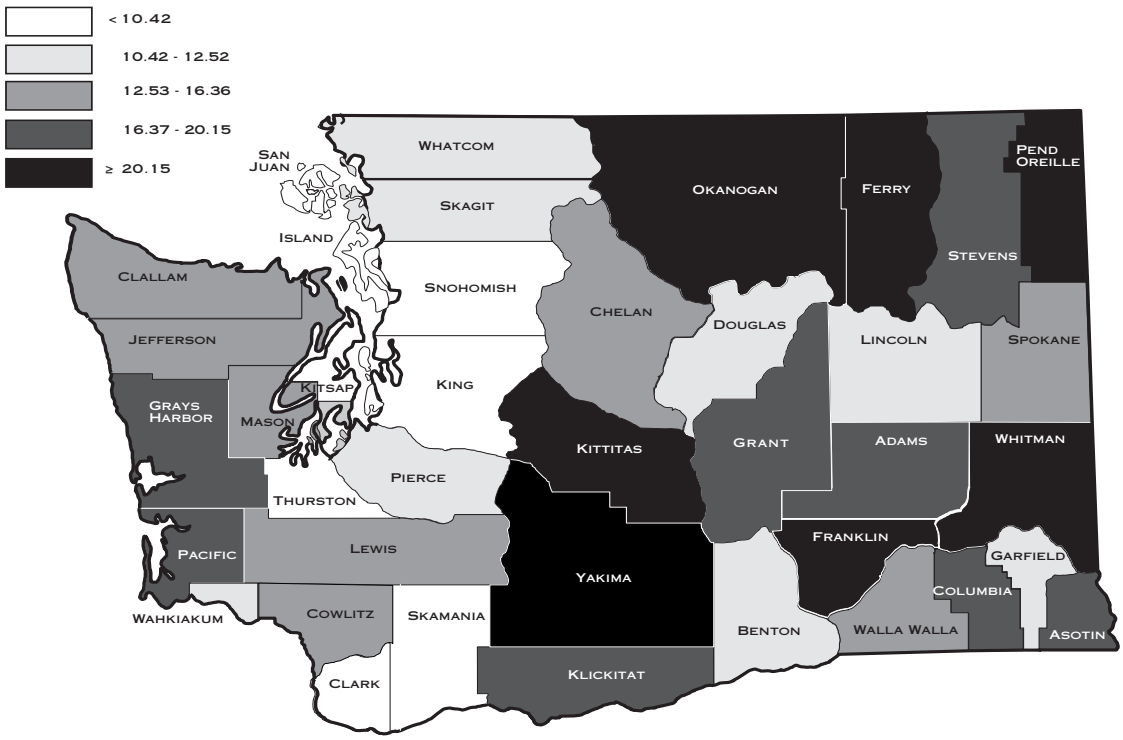
Infant Deaths per 1,000 Births



Source: Center for Health Statistics, Division of Health Information, Department of Health

Poverty Rate by Washington State County – 1990

Percent of Population Below Federal Poverty Level



Source: U.S. Department of Commerce Bureau of the Census. Census of Population and Housing: 1990

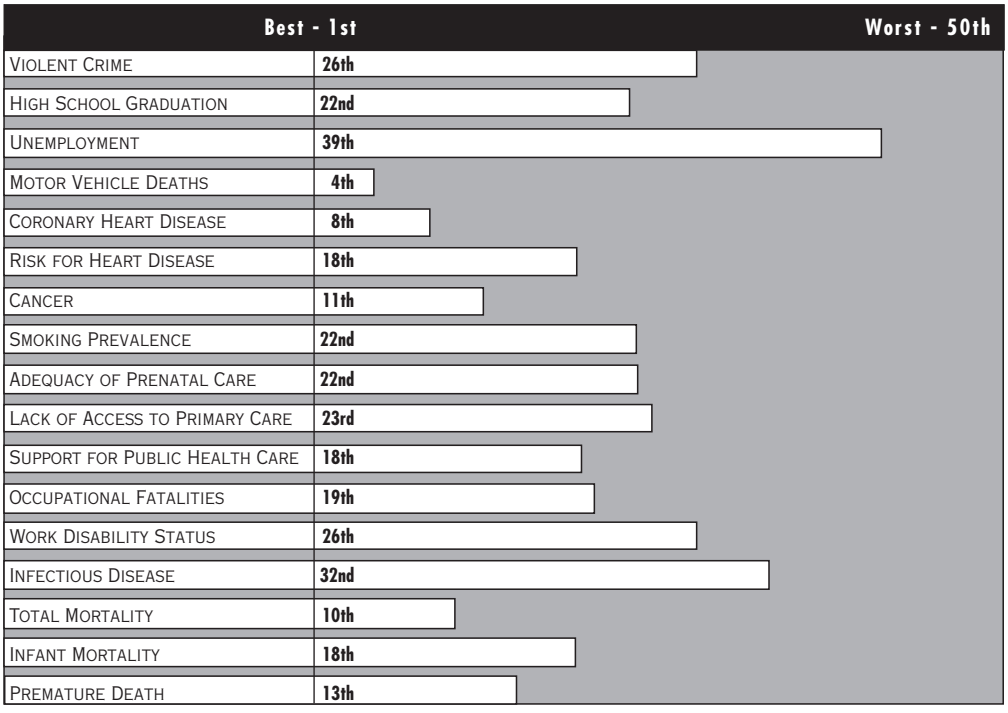
How Healthy are Washington Residents?

The World Health Organization defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."

In a 1995 report by ReliaStar Financial Corporation, Washington ranked 17th among states with the healthiest populations. The *ReliaStar State Health Rankings* rated states on several health criteria including: lifestyles, access to health care, occupational safety and disability, disease, and mortality rates.[1] In 1994, the average life expectancy in Washington was reported at 77.4 years, compared to 75.7 nationally.[2] Note that the *ReliaStar* study is only one of many reports ranking states on a variety of health indicators.

Despite Washington's above average overall ranking, an examination of specific health indices reveals a number of problems. Coordinated efforts are needed to resolve many of these issues, thereby improving the health of our people and preventing further deterioration of health standards.

Washington's Health Ranking Among the 50 States



Source: ReliaStar Financial Corporation, *The ReliaStar State Health Rankings - 1995*

[1]ReliaStar Financial Corporation, *The ReliaStar State Health Rankings, 1995 Edition.*
[2]Center for Health Statistics, Division of Health Information, Department of Health, 1995*;* National Center for Health Statistics, Hyattsville, MD.

Order form and Request for Information

We hope you have found the *1996 Washington State Public Health Report* useful. We would appreciate it if you would take a few moments to complete this information sheet and let us know how you intend to make use of the *Report*. Your response will aid us in developing future *Reports*, so we encourage your participation. Additional copies can be requested by using this form.

When you have completed the form, please fold it, add a stamp, and mail to the address on the reverse side.

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1. How have you used (or will you use) the *State Public Health Report*? _____

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☐ Yes, I would like _____ additional copies of the *1996 State Public Health Report*.

☐ My address is the same as above.

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If you have any questions, please contact us at (360) 586-0399 FAX (360) 586-6033. Thank You.

1996 Washington State Public Health Report - Washington State Board of Health

Our Vision of a Healthy Washington

WE ENVISION A FUTURE IN WHICH:

- Children are born healthy in a society that respects and nurtures individuals throughout life, providing each with the opportunity to develop and express her or his potential in ways that are personally satisfying and socially constructive.
- The environment we share is clean, with physical, chemical and biological hazards reduced to levels compatible with both community health and a sound economy.
- Individuals care for themselves and others and have the opportunity to learn and apply health-promoting practices in family, school and other community environments.
- Infectious diseases are controlled, and other preventable illnesses and injuries are minimized.
- All citizens who need special support or care in order to continue to be part of a fulfilling community life receive what they need.
- Informed and interested citizens participate actively in formulating health policy and deciding how public and private resources will be allocated for health maintenance and improvement.
- Public agencies cooperate and collaborate with each other and with private sector organizations in addressing problems that put people at risk of illness or injury and impact community health status.
- Individuals and institutions have an abiding commitment to the responsible use of health and medical care services.
- A flexible and creative health and illness care system respects cultural and geographic diversity, focuses on outcomes and responds proactively to emerging health problems as it emphasizes prevention, education, and early intervention, and makes quality affordable care readily available and accessible to all.

With this vision of our future, we look forward to living in a society in which the quality of the public's health is transformed from a liability demanding attention and engagement to an asset enabling us to meet the challenges of the twenty-first century.

FOLD HERE TO MAIL

Washington State Board of Health
PO Box 47990
Olympia, WA 98504-7990

The State Board of Health

RCW 43.20.030 specifies details of the State Board's composition and appointment. The State Board of Health has ten members, nine of whom are appointed by the Governor. The tenth member is the Secretary of the Department of Health, or designee.

Required Board membership includes:

- Four people experienced in matters of health and sanitation;
- An elected city official who is a member of a local health board;
- An elected county official who is a member of a local health board;
- A local health officer;
- Two people representing consumers of health care.

The chair of the State Board is selected by the Governor from the nine appointed members.

Prior to making appointments to the State Board, the Governor is required to consider recommendations of several organizations:

- Association of Washington Cities (for the elected city official);
- Washington State Association of Counties (for the county official);
- Washington State Association of Local Public Health Officials (for the local health officer);
- State Council on Aging (for one of the consumer representatives).

The Governor also invites recommendations from other organizations and individuals.

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Sheri S. Barnard

William Budd, Ph.D.

The Honorable Neva J. Corkrum

Rory M. Laughery, M.D.

Thomas H. Locke, M.D., M.P.H.

Bruce Miyahara, M.H.A.

The Honorable Margaret Pageler, J.D.

Florence Reeves, R.N., B.S.N.

Vice-Chair: Merlyn H. Sayers, M.D., Ph.D.

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